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In The

Supreme Court of the United States

KELLY AYOTTE, ATTORNEY GENERAL,
IN HER OFFICIAL CAPACITY,

Petitioner,

v.

PLANNED PARENTHOOD OF
NORTHERN NEW ENGLAND, ET AL.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The First Circuit

BRIEF AMICI CURIAE OF LOREN LEMAN, LIEUTENANT GOVERNOR OF THE STATE OF ALASKA, AND ALASKA LEGISLATORS IN SUPPORT OF PETITIONER

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TABLE OF CONTENTS

	Page
INTEREST OF AMICI	1
SUMMARY OF ARGUMENT	2
ARGUMENT	5
I. PARENTAL INVOLVEMENT LAWS EFFECTIVELY SERVE TO PROTECT MINOR GIRLS FROM THEIR OWN IMMATURITY	5
II. PARENTAL INVOLVEMENT LAWS EFFECTIVELY SERVE TO PROTECT THE PHYSICAL, EMOTIONAL, AND PSYCHOLOGICAL HEALTH OF MINOR GIRLS	8
III. PARENTAL INVOLVEMENT LAWS HELP PROTECT YOUNG GIRLS FROM SEXUAL ABUSE AND HELP CATCH ADULT MALE SEX OFFENDERS	17
IV. YOUNG GIRLS VERY OFTEN NEED ENCOURAGEMENT TO CONSULT THEIR PARENTS REGARDING PREGNANCY AND ABORTION, EVEN IN LOVING AND FUNCTIONAL FAMILIES	20
V. PARENTAL INVOLVEMENT LAWS HELP FOSTER AND PROTECT THE FAMILY STRUCTURE	23
CONCLUSION	24

TABLE OF AUTHORITIES

Page

CASES:

Planned Parenthood of Blue Ridge v. Camblos, 155 F.3d 362 (4th Cir. 1998) 5

Troxel v. Granville, 530 U.S. 57 (2000) 4

MISCELLANEOUS:

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INTEREST OF AMICI[1]

The Amici Curiae who present this brief to the Court include Alaska Lieutenant Governor Loren Leman and the following members of the Alaska Legislature: Senator Fred Dyson; Senator Lyda Green; Senator Ralph Seekins; Senator Gary Stevens; Senator Gary Wilken; Representative John Coghill; Representative Nancy Dahlstrom; Representative Carl Gatto; Representative Mike Kelly; Representative Vic Kohring; Representative Bob Lynn; Representative Mark Neuman; Representative Donald Olson; Representative Bill Stoltze; and Representative Peggy Wilson.

In 1997, then a member of the Alaska Senate, Alaska Lieutenant Governor Loren Leman was the principal sponsor of the Alaska Parental Consent Act ("the Act"). The Act, which requires that minor girls ages 16 and younger obtain either one parent's consent or a judge's approval before obtaining an abortion, is similar in many respects to New Hampshire's Parental Notification Prior to Abortion Act ("the N.H. Act"). On behalf of the State of Alaska, therefore, Lieutenant Governor Leman has a significant interest in the resolution of this case. The Alaska legislators who have placed their names on this brief either supported passage of the Act in 1997 or support its enforcement at this time.

In *Planned Parenthood of Alaska v. State*, Case No. 3AN-97-6014 Civ., the State of Alaska defended the Act from constitutional challenge under various provisions of

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[1] The parties have consented to the filing of this brief.

Counsel for a party did not author this brief in whole or in part. The North Star Civil Rights Defense Association, Inc., an Alaska nonprofit corporation, made a monetary contribution to the preparation and submission of this brief.

the Alaska Constitution. During a three-week bench trial conducted in Alaska Superior Court in January 2003, the State introduced substantial evidence in support of the Act, and in doing so built upon the evidentiary foundation laid in prior cases litigated in separate states regarding state constitutional challenges to other parental involvement acts. The Alaska Superior Court evidentiary record is the most recent and extensive record developed regarding the justifications for, and the impacts of, parental involvement laws like the Alaska and New Hampshire Acts. Lieutenant Governor Leman and the Alaska legislators summarize and present the Alaska Superior Court record to the Court in this brief because they believe that it will assist the Court in its resolution of this case.

SUMMARY OF ARGUMENT

Parental involvement laws are in the best interests of minor girls and their families. Parental involvement laws do not harm minor girls. Rather, these laws protect minor girls from their own immaturity, provide necessary adult assistance with respect to the giving of informed consent, and protect the physical, psychological and emotional health of minor girls.

In almost all cases, adolescent girls do not plan their pregnancies, are shocked by the news that they are pregnant, and consider the resulting situation to be a crisis. Pregnant minor girls need adult guidance in dealing with crisis pregnancies. The capacity to become pregnant and the capacity for mature judgment concerning the wisdom of abortion are not necessarily related. Minor girls as young as 10 or 11 can become pregnant.

Minors have a greater tendency to engage in avoidance and denial when dealing with bad situations, including pregnancy and abortion. Because adolescents typically want to avoid and escape from problems, abortion is a very seductive choice for a pregnant adolescent. If minors are not encouraged to inform and involve their parents in their pregnancy and abortion plans, and are given an option, they will most typically elect to not involve their parents in their abortion plans. Even in loving, functional families, minor girls often need encouragement to consult their parents regarding pregnancy and abortion. Minor girls often misapprehend their parents' probable reaction to their unplanned pregnancies, unreasonably expecting an overly negative reaction. Left to their own juvenile devices, most adolescent girls do not seek suitable adult advice regarding abortion and they often succumb to pressure and power differentials. Most often, when a parent is not involved in a young girl's abortion plans, a boyfriend is involved. Two-thirds of the time the boyfriend is an adult sex-offender.

Minors typically do not have experience in navigating the healthcare system and in choosing qualified and safe physicians, who will adequately explain the abortion procedure and possible complications when obtaining informed consent. Parents, when aware of their daughter's abortion, are more able to monitor their daughter for physical and psychological complications and assure her adequate follow-up treatment. On their own, minors tend to be unreliable at following medical instructions. With parental assistance, a minor's compliance with medical instructions and treatment plans and, thus, their safety increase greatly.

Parental involvement laws help protect young girls from sexual abuse and help catch adult male sex offenders. When a girl age 16 or younger is pregnant there is a two-thirds

chance that she has been sexually assaulted by a male 6-7 years older. Boyfriends push young girls toward abortion to avoid legal obligations, either criminal or financial. A parent or a judge would be very likely to discover and report sexual abuse when a minor girl approaches them for consent to an abortion. By contrast, abortion providers are unreliable in reporting sex abuse. Ending sexual abuse is always in a minor girl's best interests. Parental involvement or judicial consent helps to ensure that a minor girl will not be pressured into an abortion by a boyfriend, typically an older adult male, who is selfishly seeking to avoid criminal or financial responsibility.

Parental involvement laws encourage but do not ultimately require young girls to consult their parents regarding abortion. In states with parental involvement laws, the percentage of girls involving their parents in their abortion plans has significantly increased after enactment of the laws even though judicial bypass is available. Parental involvement laws are in the best interests of both minor girls and their families because they have the effect of fostering and protecting the family structure. A parent's right to custody, control and management of a minor child is a fundamental liberty interest protected by the United States Constitution.[2] As the United States Court of Appeals for the Fourth Circuit has explained, this fundamental right "is at its zenith when the decision as to which parental involvement is urged is one – like the abortion decision – with profound and enduring consequences not merely for the physical well-being of the child, but for the child's spiritual, moral, and

[2] *Troxel v. Granville*, 530 U.S. 57, 65-66, 68 (2000).

emotional development."[3] This Court should uphold the N.H. Act.

ARGUMENT

I. PARENTAL INVOLVEMENT LAWS EFFECTIVELY SERVE TO PROTECT MINOR GIRLS FROM THEIR OWN IMMATURITY.

Experience makes an enormous difference in improving the quality of adolescent decision making. Thus, chronological age distinctions are extremely significant because experience is acquired over time. Lack of experience affects a minor girl's ability to make decisions regarding abortion. [App. 119a-123a][4] Minors tend to base decisions upon misperceptions and misunderstandings. [App. 189a-190a, 191a-192a] The typical minor will misapprehend her

[3] *Planned Parenthood of Blue Ridge v. Camblos*, 155 F.3d 362, 368 (4th Cir. 1998).

[4] Citations to "App. ___a" are to pages of the official transcript of the trial in *Planned Parenthood of Alaska v. State of Alaska*, Case No. 3AN-97-6014 (Alaska Super. Ct. 2003) which have been reproduced in Appendix A. Amici have reproduced portions of the trial transcript in Appendix A of this brief and for the Court's convenience have replaced the original transcript page numbers with appendix numbering. Citations to "App. ___b" are to pages contained within the transcripts of depositions taken in *Planned Parenthood of Alaska v. State of Alaska*, Case No. 3AN-97-6014 (Alaska Super. Ct. 2003). The deposition transcripts cited were entered into evidence and comprise part of the record in *Planned Parenthood of Alaska v. State of Alaska*, Case No. 3AN-97-6014 (Alaska Super. Ct. 2003). Citations to "App. ___c" are to pages in the official trial transcript of *N. Fla. Women's Health & Counseling Servs, Inc. v. Florida*, Case No. 99-3202 (Fla. Cir. Ct. 1999). The portions of the Florida trial transcript cited were entered into evidence and comprise part of the record in *Planned Parenthood of Alaska v. State of Alaska*, Case No. 3AN-97-6014 (Alaska Super. Ct. 2003).

parents' probable reaction to her unplanned pregnancy, unreasonably expecting an overly negative reaction. [App. 6a-8a, 36a-41a][5] The capacity to become pregnant and the capacity for mature judgment concerning the wisdom of abortion are not necessarily related. [App. 110a-111a, 175a-180a] Minor girls as young as 10 and 11 can and do become pregnant.[6] [App. 158a]

In almost all cases, adolescent girls do not plan their pregnancies, are shocked by the news that they are pregnant, and consider the resulting situation to be a crisis. [App. 105a-108a] Minors have a greater tendency than adults to engage in avoidance and denial when dealing with bad situations, including pregnancy and abortion. [App. 2b-4b] Because adolescents typically want to avoid and escape from problems, abortion is a very seductive choice for a pregnant adolescent girl. [App. 119a-123a] Studies reflect that if minor girls are not encouraged to

[5] The great majority of parents (a) are supportive of their minor daughters when they are faced with an unplanned pregnancy and contemplating an abortion; and (b) will assist their daughters in making informed and intelligent decisions regarding abortion. [App. 6a-8a, 36a-41a, 175a-180a] Most parents tend to support their daughter's decision when they are informed before her abortion but are more likely to be angry or disappointed if they find out about the abortion only after the event. [App. 22a-24a]

[6] Some abortion providers recognize the existence of this gap between fertility and maturity and take measures to accommodate it. For example, 1993 Alaska ACLU Citizen of the Year Dr. Susan Lemagie, who is the Medical Director of Planned Parenthood of Alaska, believes that girls up to the age of 15 need adult involvement in their medical decision making. [App. 4a] Dr. Lemagie also admitted that she does not provide "medical abortions" (*i.e.*, non-surgical abortions) to girls ages 16 and under because she does not believe that girls in this age range can handle the process without parental or other adult supervision. [App. 4a-5a] Dr. Lemagie believes that parental involvement in abortion is an excellent idea for adolescent girls. [App. 3a-4a, 5a-6a]

inform their parents of their pregnancy and abortion plans and are given an option, they will elect to not involve their parents in their abortion plans. [App. 7b-8b] Minors tend to delay responding to an unplanned pregnancy because of their (1) inexperience in recognizing the symptoms of pregnancy, (2) reluctance to accept the reality of their situation, (3) lack of knowledge of where to seek advice, and (4) hesitation to confide in adults. [App. 28a-31a, 70a-75a][7]

Minors do not process information in the same way as adults. [App. 109a-110a] Minors often lack the ability to make fully informed choices that take account of both immediate and long-range consequences. [App. 8b-14b][8] Minors have a propensity to make decisions based upon emotions rather than information and logic. They are unlikely to think things through cognitively and are not typically capable of analyzing multiple variables in their decision making. Adolescence is a period of fluctuating

[7] Minors often delay their abortion decision because of their immature characteristics and their lack of experience, the combination of which often leads to denial. [App. 28a-31a, 75a-76a] Because they do not know where to seek appropriate advice and hesitate to confide in their parents, girls often turn to their boyfriends. "Power differentials" exist between minor girls and their older male boyfriends, and vulnerable pregnant adolescent girls often succumb to their older boyfriend's wishes regarding abortion. [App. 1c-3c] An adolescent girl's pregnancy is a sign of her vulnerability and is a reflection of developmental failure in her decision making. [App. 112a-117a]

[8] Adolescents often resist things which are good for them and require parental assistance in order to make good decisions. [App. 112a-117a] A minor's failure to take into account both immediate and long-range consequences in their decision making is particularly evident in the emotionally charged context of abortion. [App. 175a-180a; 8b-14b]

emotions and intellectual abilities. [App. 119a-123a][9] Placing minors in positions where they are required to make adult decisions puts enormous emotional pressure and stress upon them, thus making them more susceptible to immature, self-conscious and risk-taking behaviors. [App. 8b-14b][10]

Minors' brains are underdeveloped and under construction, with brain development continuing through age 20. [App. 111a-112a] The underdevelopment of minors' brains detrimentally affects the quality of their decision making and thereby diminishes the ability of a minor acting alone to bring mature insight and judgment into the abortion decision-making process. [App. 112a-117a]

II. PARENTAL INVOLVEMENT LAWS EFFECTIVELY SERVE TO PROTECT THE PHYSICAL, EMOTIONAL, AND PSYCHOLOGICAL HEALTH OF MINOR GIRLS.

The physical, emotional, and psychological consequences of abortion are serious and can be lasting, particularly when

[9] It is very typical for adolescents to want independence ("leave me alone") but at the same time to very much want parental guidance. [App. 112a-117a] Abandoning adolescents completely to their own decision making is most often frightening to them. [App. 119a-123a]

[10] Minors tend to be more impulsive in their decision making. [App. 70a-75a] They tend to think of themselves as being "center stage," with everyone watching them, and their decision making tends to be dominated by this type of self-conscious thinking. Minors also tend not to think of themselves in terms of negative effects, believing that although bad things happen to other people, bad things will not happen to them. All of this immature thinking leads minors to be very susceptible to peer pressure, pressure from others, and higher levels of risk taking. [App. 8b-14b] Minors are often unable to correctly interpret their environment, and thus they have difficulty planning appropriate responses. [App. 109a-110a]

the patient is young and immature. [App. 43a-52a] The short-term health risks of abortion are bleeding, infection, damage to internal organs, retained products of conception (*i.e.*, incomplete abortion), anesthesia-related complications, and death. [App. 43a-52a, 164a-167a, 167a-175a] The long-term health risks of abortion include fetal loss related to pre-term babies, low birth-weight babies, placenta previa, sterility or loss of fertility, and an increased risk of breast cancer. [App. 43a-52a][11] No less real than the physical consequences are the emotional or psychological health risks of abortion which include depression, post-traumatic stress, suicidal ideation, psychiatric admissions, and substance abuse. [App. 43a-52a, 61a-66a, 118a-119a][12]

[11] An early full term pregnancy will reduce a woman's risk of breast cancer later in life. [App. 52a-53a, 56a-57a] A minor girl who aborts her pregnancy and thus does not carry her pregnancy to term, increases her risk of developing breast cancer later in life. [App. 43a-52a, 56a-57a] This increased risk of breast cancer is exacerbated if the girl has a family history of breast cancer. [*Id.*; 1b-2b] Minors are most often unaware of a history of breast cancer in their extended family and a parent, particularly a mother, is more likely to be aware of a family history of breast cancer and to factor this information into [illegible] abortion decision. [App. 36a-41a]

[12] The suicide rate for women is six times greater among those who have had abortions. [App. 55a-56a] The 1998 Soderberg study of 854 women who had undergone induced abortions, revealed that 50-60% had "experienced some measure of emotional distress, classified as severe in 30% of the cases." [App. 1c-3c] In acknowledgment of this risk, Dr. Lemagie refers 100% of her abortion patients to counseling. [App. 8a-11a]. Minor girls are at greater risk than adult women for emotional and mental effects after abortion. [App. 42a-43a, 112a-117a] Women who have later term abortions have a greater chance of negative emotional responses. [App. 42a-43a] Minors tend to delay their abortion decisions. [App. 28a-31a, 75a-76a] Sixty percent (60%) of girls under fifteen years old wait until after eight weeks gestation before seeking abortion advice, and 25% wait until after twelve weeks. [App. 14a-15a]

The abortion process itself presents serious health risks for the young girl that warrant parental involvement. [App. 155a-158a] First trimester abortion procedures for girls ages 16 and younger require two days. [App. 81a-82a] On the first day, the girl meets with a staff member who obtains a medical history and provides abortion counseling.[13] The girl then meets with a nurse mid-wife, who obtains her consent and inserts the Laminaria[14] into her cervix. [App. 83a-84a, 85a-86a, 86a-87a] The young girl does not meet with the doctor that day but rather must go home with the Laminaria inserted and return to the clinic the following day for the actual abortion procedure. If the girl fails to return the following day to have the Laminaria removed, she can suffer severe complications including infection, sterility, loss of the uterus/ovaries, and death. [App. 92a-95a, 155a-158a][15]

Minors are notoriously unreliable in following medical care instructions, and thus, the risks inherent in abortion are compounded for minor girls. However, minors' compliance in following medical treatment plans greatly increases when they have the assistance of a parent. [App. 55a, 98a-105a, 108a-109a, 155a-158a] Moreover, even if

[13] Abortion providers typically do not have adequately trained staff members for purposes of counseling minor girls regarding abortion. [App. 118a-119a]

[14] The Laminaria is a "sterile rod made of kelp which is hydrophilic, and, when placed in the cervix canal, absorbs moisture, swells, and gradually dilates the cervix." *Stedman's Medical Dictionary* p. 934 (Williams & Wilkins 26th ed. 1995); [App. 81a-82a]

[15] Insertion of the Laminaria introduces a pathway for infection to travel from the vagina to the uterus. [App. 84a-85a] Once infection "seeds," a mere 4-8 hours of the infection growing and spreading is very serious. [App. 164a-167a]

the girl would follow the medical instructions on her own, unaware parents could plan travel or other family engagements that conflict with the young girl's necessary return visit to the abortion clinic. [App. 92a-95a]

The safety of minor girls also depends upon the selection of a competent and experienced abortion provider. Most girls have no experience in evaluating and selecting a physician. Thus, they frequently need parental or adult assistance in selecting a competent and experienced provider. [App. 42a-43a, 70a-75a, 155a-158a] Selection of an abortion provider is an important decision because doctors performing abortions vary in skill, experience, and procedure.[16] Minor girls demonstrate their inexperience and difficulty in selecting an abortion provider when they select doctors who do not provide adequate counseling or screen individuals for ability to understand the procedure and give informed consent.[17]

[16] There is a major difference of opinion regarding proper abortion procedure. One school of thought and practice believes that performing D&E abortions without using ultrasound to check for complete removal of the fetal tissue is unsafe [App. 70a-75a], while the other does not believe it necessary to use the safeguard of an ultrasound in performing a D&E abortion procedure. [App. 70a-75a] D&E, which stands for dilation and evacuation, is the abortion procedure used most prevalently after 12 weeks gestation, and involves (a) dilation of the cervix using a Laminaria and then (b) the evacuation of the uterus by suction via the use of vacuum aspiration and/or by grasping and removing fetal parts via the use of forceps. Paul, et al., *A Clinician's Guide to Medical and Surgical Abortion*, Ch. 10, pp. 123, 125, 131-136 (Churchill Livingstone, 1999).

[17] A parent is unlikely to select a doctor who approves patients uniformly for a procedure without regard to the patient's particular circumstances or cognitive abilities. Though the ability to give informed consent is not merely a function of age, it is unthinkable that a competent doctor, who spends his career performing abortions on both women

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Parental involvement laws provide for necessary adult assistance in giving informed consent. An unaccompanied minor is not as able as a typical adult woman to understand the risks of abortion and make an informed, intelligent decision about whether to undergo the procedure. [App. 117a-118a][18] Most minor girls do not have the brain, intellectual, and emotional development required to enable them to give informed consent to a serious medical procedure like abortion without assistance from a parent or guardian. Minors' natural immature, self-conscious, and overly positive thought processes lead them to be susceptible to pressure from others and risk-taking, which is detrimental to informed, intelligent decision making. [App. 105a-108a, 117a-118a; 8b-14b]

The physician or nurse mid-wife performing the abortion does not serve as an adequate substitute for a loving, involved parent in assisting a girl to understand and consent to the procedure.[19] Family is the best support

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and girls as young as 12, could never have met a single minor patient incapable of giving truly informed consent. Some doctors' habits of uniformly accepting the consent of minor girls for abortion reflect a belief that fertility, rather than age or intellectual and emotional maturity, equals ability to give informed consent. [App. 64a, 72a-74a]

[18] Some girls ages 16 and under cannot independently give informed consent to pregnancy related medical procedures. [App. 67a-69a] No medical studies show that girls 16 and under are capable of giving informed consent. Having parents involved in obtaining informed consent for minor girls is advisable. [*Id.*] A supportive parent is extremely helpful in managing a young girl's pregnancy and doctors sometimes need to call upon parents to help convince a young girl to follow sound medical advice. [App. 69a-70a, 57a-58a]

[19] Generally, girls do not obtain abortions from doctors with whom they have a prior relationship. [App. 53a-55a] The doctor chosen does not know the girl nor does the doctor or nurse spend enough time with her to be able to give adequately individualized information and

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for a young girl choosing whether to undergo an abortion. [App. 58a-60a, 175a-180a][20]

Minor girls also need the help of an adult in safely dealing with post-abortion complications. Following an abortion, a young girl needs to be monitored for anesthesia-related complications, heavy or prolonged bleeding, infections, fever, uterine or colon perforation, and emotional and psychological effects. [App. 43a-52a, 154a-167a][21]

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support to each unique girl. The average abortion provider cannot adequately assess the minor girl, her emotional and physical state, her medical and emotional history, and obtain an informed consent from her for the abortion procedure in the few short minutes he spends with her. Five to seven minutes with a doctor is no substitute for a parent who for many years has sought what is in the best interests of a daughter. [App. 53a-55a, 85a-87a] Minors simply do not know how to negotiate the healthcare system alone because they lack that particular life experience. [App. 189a-190a] Most minors, especially when in a state of crisis, cannot reasonably be expected to digest and understand the informed consent forms which physicians present to them for signing prior to performing an abortion. [App. 36a-41a, 98a-108a, 117a-118a] The great majority of parents are beneficial in helping their minor daughters to consider all of the risks and benefits associated with abortion and other options available in responding to an unplanned pregnancy and to give informed consent to the abortion procedure. [App. 36a-41a, 97a-98a, 138a-143a, 175a-180a]

[20] Most parents, when informed of a young daughter's pregnancy, support her abortion decision. [App. 175a-180a] When parents share responsibility for the abortion decision with their daughter, they relieve the young girl of unnecessary and unhealthy stress and guilt. [*Id.*] The adequacy of the doctor-patient relationship is negatively affected by the young age of a minor patient and is positively affected by an involved parent. [App. 46a-86a] A study conducted by Dr. Stanley Henshaw reveals that a significant percentage of the young girls who completed a questionnaire for abortion clinics *prior to the abortion procedure*, reported that they were being forced to have an abortion *but, nonetheless*, were provided abortions by the clinic. [App. 20a-22a]

[21] Because they have an immature cervix and because they delay their abortion decisions, girls 16 years and younger are more likely

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A young girl is much more likely to receive timely and adequate post-abortion medical observation and care if her parent(s) are aware of her pregnancy and abortion. [App. 66a-67a, 155a-158a, 160a-163a, 167a-175a] Without parental involvement, minor girls tend to delay seeking medical care for abortion complications. Abortion providers tell girls that they will experience some degree of pain and bleeding, so when they experience pain and bleeding following the abortion they tend to think things are fine. Young girls tend to not recognize as quickly on their own when their pain is too great, their bleeding too prolonged or too heavy, and that they need medical attention. [*Id.*]

Minors want the abortion experience to end; thus, they often deny that they are experiencing problems. [App. 160a, 160a-163a, 167a-175a] Having not informed their parents of their pregnancy and abortion, many times the

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than older females to have post-abortion complications. [App. 4b-8b] Furthermore, parents cannot adequately monitor a daughter for depression and suicide risks if they are unaware of her abortion. Minors are at greater risk to experience negative emotional or psychological health consequences from abortion than adult women. A minor who keeps her abortion secret from her parents or guardian is more likely to suffer negative emotional and psychological health responses after her abortion. [App. 119a-123a, 123a-126a, 175a-180a] Minors who keep secrets from their parents about important issues in their lives tend to be more depressed and experience more emotional pain. Secrecy is not healthy between a minor and parents and causes the minor excess anxiety. [App. 119a-123a, 123a-126a, 175a-180a] The emotional and psychological health risks associated with having an abortion can often be long-lasting. [App. 61a-66a] A minor who has an abortion with the knowledge and support of her parents or guardian is more likely to be healthy emotionally and psychologically in the years immediately following her abortion and later in her life. [App. 118a-119a, 123a-126a] Informed parents are generally in the best position to provide long-term emotional support to a minor after an abortion. [App. 4b-8b]

girls also try to hide the symptoms of abortion complications from their parents. [App. 4b-8b] All of these factors lead to delayed medical care for the minor girl to treat her abortion complications. [App. 160a, 160a-163a, 167a-175a]

Outside of an emergency, physicians must obtain parental consent to treat a minor girl for an abortion complication. [App. 55a-56a] By treating them the same as adults and leaving the post-abortion care up to the minor, abortion providers do not take adequate steps to ensure that minor girls receive necessary post-abortion care. [App. 95a-96a] These girls are responsible for following an antibiotic regimen in order to fend off infection. [App. 96a-97a] Only 30% of women, including adults, return to the abortion provider for follow-up care. [App. 28a-31a, 55a] When a minor girl does not inform her parents about her abortion, delay in seeking post-abortion complication care occurs in 80-90% of the cases, and the average resulting delay is anywhere from six to twelve hours. [App. 160a-163a, 167a-175a]

Abortion complications can become very serious very quickly. [App. 164a-175a] Death can result if infection is allowed to grow and spread through the uterine cavity and then outside the fallopian tubes and into the blood stream. Sterility can result if the infection is allowed to last and scar the fallopian tubes. Prolonged bleeding can result in under-perfusion of the organs, including brain, heart, and kidneys, which can lead to negative consequences up to and including death. *Id.* Complications related to bleeding or infection can become very serious in a mere four to eight hours. Uterine perforation with colon perforation causes infection to grow and spread much more quickly because so much bacteria is introduced into the abdominal cavity. *Id.* Excessive bleeding can result simply from the

scraping of the uterus wall during the abortion procedure and, thereafter, a lack of constriction of the uterus and blood clotting. In the case of heavy bleeding, even four hours of delay can be disastrous for the young girl. *Id.*

In the great majority of cases, parents or guardians are in a better position than a minor acting alone to monitor for adverse emotional or psychological consequences following an abortion. However, parents or guardians cannot adequately monitor the minor for such consequences if they are not made aware of the abortion. [App. 119a-123a, 125a-126a]

When parents are involved in a young girl's post-abortion care, the girl comes earlier to seek medical care for complications. [App. 70a-76a] Parents who are aware of the abortion can watch the girl's physical condition for symptoms and help piece symptoms together to recognize a serious medical problem more quickly. Some symptoms of abortion complications are internal and some are subtle, recognizable only by their severity, like excessive pain, excessive or prolonged bleeding, and high fever. Timely medical treatment for abortion complications cuts down on the severity of the complications. [App. 160a-163a, 167a-175a]

When parents are aware of their daughter's abortion prior to bringing her to the emergency room for care related to an abortion complication, they are more quickly and accurately able to inform the hospital personnel what their daughter's health problem is and to focus on getting her the medical care she needs. Emergency room staffs can better serve a girl experiencing an abortion complication when they learn of the abortion quickly from informed

parents, do not have to discover the abortion for themselves through medical tests and analysis, and do not have to deal with shocked parents upon learning for the first time of the abortion. [App. 160a-163a] The great majority of parents who learn of their minor daughter's abortion are involved and beneficially supportive in helping the minor receive post-abortion medical care, including care related to abortion complications. [App. 160a-163a, 167a-175a]

III. PARENTAL INVOLVEMENT LAWS HELP PROTECT YOUNG GIRLS FROM SEXUAL ABUSE AND HELP CATCH ADULT MALE SEX OFFENDERS.

A substantial number of pregnant minor girls have been impregnated by men whose ages make them guilty of sexual abuse of a minor. These men are typically an average of between 6-7 years older than the minor girl. [App. 143a-151a, 151a-152a][22] Stopping the sexual abuse of a minor girl is always in her best interests. [App. 123a-125a]

Parental involvement laws reasonably help to facilitate the discovery and reporting of physical abuse and sexual assault against minors. [App. 193a-196a] A parent/guardian is more likely to discover and report physical

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[22] In his study regarding minor girls and abortion decision-making, Dr. Henshaw, who regularly testifies for Planned Parenthood in abortion litigation, possessed information regarding how many of the impregnating boyfriends were over the age of twenty-one but chose not to report the data. [App. 24a-28a] Dr. Henshaw does not believe that prosecution of statutory rape is particularly beneficial to a minor girl. [*Id.*]

and/or sexual assault against their minor daughter or ward if they are aware of and involved in her pregnancy and abortion decision-making. [*Id.*] Additionally, a judge is very likely to discover physical and/or sexual assault/abuse committed against a minor seeking parental bypass. [App. 78a-79a, 186a-187a] When left to their own decisions, pregnant minor girls most often turn to the boyfriend who impregnated them for assistance. [App. 13a-15a][23]

Despite being mandated to report the suspicion of sexual abuse, abortion providers do not screen for or report sexual assault or abuse that has been committed against the minor girls who come to them for abortions without a parent or guardian. [App. 87a-90a] In 2002, Life Dynamics conducted an investigation of Planned Parenthood and National Abortion Federation clinics across the nation. A female employee of Life Dynamics called the clinics and presented herself as a thirteen-year-old girl having a sexual relationship with a twenty-two-year-old man who wanted an abortion without her parents being made aware. [App. 188a-189a]

The results of the investigation unequivocally demonstrate that abortion clinics do nothing to end the sex abuse of minors but rather further such abuse through their advice and inaction. Over 90 percent of the more than 800

[23] Ninety-three percent (93%) of girls sixteen years of age and younger who do not inform or involve their parents in their pregnancies, turn to their boyfriends for assistance. [App. 24a-28a, 138a-143a] In 36% of these cases, the boyfriend tries to persuade the girl to have an abortion. [App. 24a-28a] Boyfriends push girls toward abortion to avoid legal obligations. [App. 138a-143a]

clinics contacted failed to uphold their mandatory reporting duties. *See* Mark Crutcher, *Child Predators*, 3 (2002) *available at* www.childpredators.com/Forms/Child Predators.pdf. Most of the clinic workers acknowledged that the caller's sexual relationship was illegal and that they were required to report it to the authorities. *Id.* However, instead of reporting the abuse, clinic workers often told the caller not to give them any more information, such as her name, and then coached her on how to obtain an abortion while avoiding detection of her boyfriend's age. *Id.* Some of the coaching included advising her to call the next closest abortion clinic and then lie about her or her boyfriend's age, instructing her to come to the abortion clinic with the assurance that no age identification would be taken, instructing the girl to get her abortion in a nearby state where no parental involvement law existed, and even telling the girl to lie to a judge about her partner's age when pursuing a judicial bypass. *Id.* at 3-4. Many clinics offered the caller birth control that she could pick up when she came to the clinic, and some even said her adult boyfriend could pick up the contraceptive for her. *Id.* at 4. Abortion providers do not effectively report sexual abuse.

Male perpetrators of sexual abuse against minor girls have a great incentive to pressure and otherwise convince the girls to have abortions so as to hide the fact of the abuse and to destroy the DNA evidence of the sex crime. [App. 193a-196a] Minor girls are more likely to be influenced or coerced into having an abortion by their adult boyfriends or others than are adult women. [App. 24a-28a, 1c-3c] It is significantly more likely that DNA evidence of a sex crime committed against an impregnated minor will be preserved if the minor is required to have either a parent's

or a judge's consent before obtaining an abortion. [App. 193a-196a][24] With the preservation of evidence and the awareness of parents, many girls will no longer be subjected to sexual abuse.

IV. YOUNG GIRLS VERY OFTEN NEED ENCOURAGEMENT TO CONSULT THEIR PARENTS REGARDING PREGNANCY AND ABORTION, EVEN IN LOVING AND FUNCTIONAL FAMILIES.

Most young girls do not want to inform their parents of their pregnancy and abortion plans simply out of embarrassment and fear of parental disapproval of their sexual activity. [App. 4b-8b] In states with parental involvement laws and bypass proceedings, the most common reasons given by minor girls for wanting to avoid parental involvement are: (a) fear of rejection, (b) fear of disappointing parents, (c) wanting to spare parents the problem and stress of an unplanned pregnancy, and (d) wanting to deal with the problem of the unplanned pregnancy themselves.[25] In states with parental involvement

[24] In those rare cases where a parent of a pregnant minor who is seeking an abortion is abusive, the abuse is much more likely to be detected and stopped if the minor is required to appear before a judge in a bypass proceeding and, with the assistance of an attorney, explain and demonstrate the abuse. [App. 78a-79a]

[25] In one study in which about 50% of the girls reported they had supportive parents, Dr. Henshaw found that 73% of the responding girls did not want to tell their parents about their pregnancy/abortion merely because they thought the news would "disappoint" their parents; 32% simply did not want their parents to know that they were having sex; 32% thought that their parents might make them stop seeing their boyfriend; and 25% believed that their parents had enough stress already. [App. 16a-17a]

laws, most girls who pursue judicial bypass do so despite reporting that they have positive relationships with their parents. [App. 196a-198a, 198a-203a][26]

Left to their own juvenile devices, most adolescent girls do not seek suitable adult advice regarding abortion, and they often succumb to pressure and power differentials. [App. 24a-28a] Dr. Henshaw confirmed that 93% of the time when parents do not know of a young girl's abortion, *a boyfriend* is involved in "deciding on or arranging" the abortion. [*Id.*; Stanley K. Henshaw & Kathryn Kost, *Parental Involvement In Minors' Abortion Decisions*, Family Planning Perspectives, Sept.-Oct. 1992, at 205 (hereafter "Henshaw"); *see also* App. 138a-143a] For sixteen and seventeen-year-old girls, the percentage involving a boyfriend in their abortion decision or arrangements grows

[26] A parent's initial reaction of anger and frustration at a minor daughter's unplanned pregnancy is normal and is not an indication of a dysfunctional family. [App. 152a-153a] In a study of some 490 girls pursuing parental bypass in Massachusetts, 50% of the girls reported they had positive relationships with their parents. Yet, despite these positive parent/child relationships, the girls were seeking to bypass parental involvement in their abortions. Of these girls, 22.4% were trying to avoid parental involvement simply to avoid parental disappointment, loss of parental trust, or loss of parental respect. Another 22.2% of these girls wanted to avoid parental involvement simply because their parents held ideological views about abortion. Only three of the 490 girls (0.6%) reported that they feared possible physical harm from their parents. [App. 199a-202a] It is a good thing for parents and children to communicate, and it is not necessarily abusive for a parent to share a religious view about abortion with a child. [App. 203a] Even Dr. Laurie Zabin, former board member of Planned Parenthood of America and a long time abortion advocate, admits that it can be a good thing if family communication occurs between a pregnant daughter and her parents and the result of that communication is a decision for the daughter to not have an abortion but instead to give birth to her baby. [App. 192a-193a]

to 99%. [Henshaw at 205] "[A] minor's boyfriend was more than three times as likely as her father to be involved." [Henshaw at 206] Two-thirds of the time the boyfriend is an adult who has committed a sex offense against the young girl. [App. 143a-151a, 182a-185a]

Dr. Henshaw's study reveals that only 45% of all minor girls voluntarily informed their parents of their pregnancy and abortion plans [App. 17a-20a; Henshaw at 200] and that only 47% of the girls under age sixteen whose parents were unaware of their pregnancy involved "any adult" in their abortion decision and/or arrangements. [Henshaw at 205 table 8] (for girls ages sixteen and seventeen the percentage involving "any adult" only went up to 52%) [*Id.*] By the definitional parameters of Dr. Henshaw's study, the "involvement" which the "any adult" had in the girl's abortion "arrangements" may have involved only paying for the abortion or driving to the clinic. [App. 24a-28a] "Involvement" did not necessarily include any sort of "counsel" or emotional support.

Evidence shows that without the encouragement of a parental involvement law, minors often do not tell their parents or any adult other than their boyfriend about their abortion plans. With parental involvement laws in effect, the difference is dramatic. In Texas, parental involvement in abortion decision making by minor girls has significantly increased, from 69% to approximately 95%, after enactment of that state's parental notification law. [App. 182a-185a] In Massachusetts, where the state's parental consent law has been in operation for more than twenty years, the number of girls seeking parental bypass has substantially declined from a rate of 900-1000 per year in 1991 to a rate of 450-500 in 2003. Now, approximately 75% of girls in Massachusetts consult their parents regarding

their abortion decisions. [App. 203a-205a] With the encouragement of parental involvement laws, girls most often choose to include parents in deciding whether or not to obtain an abortion.

V. PARENTAL INVOLVEMENT LAWS HELP FOSTER AND PROTECT THE FAMILY STRUCTURE.

Minors should be encouraged to include their parents in the abortion decision because parental involvement strengthens the parent-child relationship. Parental consultation is usually desirable and in the best interests of the minor girl seeking an abortion. [App. 98a-105a] It is emotionally healthy for adolescents to work through difficult issues with their parents and to face the stress of parental reactions. [App. 112a-117a] Minors who keep secrets from their parents about important issues in their lives tend to be more depressed and experience more emotional pain. Secrecy between a minor and her parents is not healthy, and it causes the minor excess anxiety. [App. 119a-123a, 123a-126a]

The family structure is also strengthened by the decline in the pregnancy rate following enactment of parental involvement laws. Despite assertions to the contrary, there is no evidence to support the notion that parental involvement laws cause increases in teen birth rates. [App. 31a-33a, 33a-35a] Dr. Henshaw explained that studies conclude minors may actually avoid pregnancy because of parental involvement laws. [Tr. 33a-35a] The Rogers Study reflects that during four and one-half years while the Minnesota two parent notice law was enforced (1981-86), teen pregnancy and abortion rates dropped while the teen birth rate continued its steady decline in

line with long term trends. [App. 33a-35a] Dr. Henshaw testified that the Rogers Study reveals the appearance of "a depressive effect on the pregnancy rate because of the [Minnesota parental notification] law." [*Id.*]

Both the teen birth and abortion rates have declined in Massachusetts since 1981. [App. 205a] Similar experiences have occurred in Indiana, Kentucky, Michigan, Mississippi, Pennsylvania, and South Carolina. [App. 126a-138a] The Texas parental involvement law appears to have caused in part a reduction in the teen pregnancy rate (5% reduction from 1999-2000), the teen abortion rate (reversing a 3-year trend of increasing rates from 1997-1999), and the teen birth rate (minors made up a smaller percentage of the overall births in 2000 than in 1999). [App. 180a-182a]. Though parental involvement laws are intended to benefit minor girls during their crisis pregnancies, by reducing the number of teen pregnancies, the laws not only ameliorate the effects of the problem but actually reduce its rate of occurrence.

CONCLUSION

Parental involvement laws are in the best interests of both minor girls and their families. Minor girls need involved parents to help navigate the health care system, monitor for complications, provide support and counsel, and put an end to the sexual abuse of minor girls. Young pregnant girls deserve the protection and support that can be provided only by parents who are aware of their daughter's condition.

For all of the above reasons, the lower court decision should be reversed.

Respectfully submitted,

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TABLE OF APPENDICES

Page

Appendix A: Trial Transcript Selections from *Planned Parenthood of Alaska v. State* 1a

Witnesses

Dr. Anderson 160a

Dr. Calhoun 153a

Ms. Collett 180a

Mr. Cooke 97a

Dr. Figley 175a

Ms. Foster 193a

Dr. Henshaw 13a

Dr. Josephson 109a

Dr. Lemagie 1a

Judge Martin 76a

Dr. Richey 67a

Ms. Sabino 196a

Dr. Shadigian 36a

Dr. Stotland 57a

Dr. Tsao-Wu 98a

Dr. Uhlenberg 126a

Dr. Whitefield 79a

Dr. Zabin 189a

Mr. Zielinski 188a

TABLE OF APPENDICES – Continued

Page

Appendix B: Deposition Transcript Selections from *Planned Parenthood of Alaska v. State* 1b

Witnesses

Dr. Adler 2b

Dr. Brind 1b

Dr. Elkind 8b

Dr. Greene 4b

Appendix C: Trial Transcript Selections from *North Florida Women's Health and Counseling Services, Inc. v. State* 1c

Witness

Dr. Adler 1c

APPENDIX A

TRIAL TRANSCRIPT SELECTIONS FROM *PLANNED PARENTHOOD OF ALASKA V. STATE* IN THE SUPERIOR COURT OF ALASKA, 2003, CASE NO. 3AN-97-6014 CIV.

TESTIMONY OF DR. LEMAGIE

Q And do you approve of Planned Parenthood's position of – that are in these tapes of telling girls that they're not going to inform the authorities about their having a relationship with an adult boyfriend?

MS. CREPPS: Objection, Your Honor. I don't think that's a precise characterization of what's in the tapes. The tapes aren't in evidence, so I would argue that there's no foundation for that statement.

THE COURT: I'm going to sustain it for lack of foundation, because I don't think this witness has heard the tapes, so unless you can. . . .

MR. DAVIS: All right, I can re – I. . . .

THE COURT: . . . . explore further on that.

MR. DAVIS: . . . . can rephrase the question. . . .

THE COURT: All right.

MR. DAVIS: . . . . and reach the same result, Your Honor.

THE COURT: I know. I'm sure you can.

Q Okay. Doctor, would you approve yourself of Planned – if, in fact, a girl was being told that Planned Parenthood was not going to inform the authorities about her relationship with an adult boyfriend?

A No, I. . . .

Q Would you approve of that?

A No, I wouldn't approve that.

Q So if this – these kind of things are occurring, then it's not with your approval; is that correct?

A Correct.

Q Now, do you approve a policy – a Planned Parenthood policy of sort of don't ask, don't tell policy, in other words, regarding revealing relationships with adult boyfriends? Would you approve that policy? In other words, just simply don't ask what the age is.

A No.

Q All right. In your own practice do you ask the age of the girl who comes in for an abortion, of the age of her boyfriend?

A Not always.

Q It's not in your forms, is it?

A No.

Q Uh-huh.

A Lots of those questions are not on my forms.

Q Right. And isn't it true that in your 23 years of experience in practicing you have yet to ever report one instance of a situation where a girl came to you for abortion services that she had been impregnated by an adult boyfriend; isn't that true?

A That's true, because I've never been – never encountered it. The only situation where I've encountered those kinds of situations are where the troopers bring the

patients to me or I go to the emergency room, where I assist in law enforcement on those issues. I'm sorry, I don't see that many 14-, 15-year-old people. I don't always ask the question because sometimes the partner's right there in the room with her and he's obviously her age.

* * *

Q But you were able to provide abortion services to girls who seek abortions with their parents; is that correct?

A Correct.

Q In fact, you agree, Doctor, that in most situations it's a great benefit to have parents involved in making decisions about medical care for children; isn't that correct? And we're talking about girls from the – in this age range from 10 to 16. Isn't that true?

A I think – I encourage all minor women to bring in their parents, and. . . .

Q And. . . .

A . . . . I think that it's very important to have as much support as possible.

Q So you agree with the statement that you think it's generally a good idea to have them there.

A If you're saying generally and it doesn't apply to all, I'll agree with you.

Q All right. Now, approximately 50 percent of the girls that you provide abortion services to you've never met before they walked in the front door; isn't that correct?

A I would say that's about right.

Q Now, regarding your treatment and prenatal care, you've gotten out of that field; is that correct?

A Correct.

* * *

Q All right. Doctor, do you believe that these children – you – when – you would agree that these children up to 15 aren't as capable of giving informed consent as an adult; is that correct?

A With the qualifications that I said before, I – I think that they're – I think that they benefit – and I think young adults, also, whatever you want to call them – benefit from adult guidance, and it doesn't make any difference who they get that guidance from, and there are certainly varying degrees of maturity with, you know, younger teenagers.

Q These young – these girls from 16 to 10 years old, you don't believe that they are able to provide the same level of postoperative care for themselves as an adult woman, do you?

A I think that if they have an adult that they can rely on, and it doesn't have to be a parent, that I would have no problems with them being able to be compliant with followup.

* * *

Q Now, regarding the patient instructions for medical abortion on page 5, is this given to the girl or is she – is this – or this read to her?

A This is given to the girl and read to her.

Q And she's told that basically if she has a fever over 102 degrees lasting more than four hours, she's supposed to inform you of this; is that correct?

A Right, because the misoprostol can induce a fever. It's a medication-induced fever. So you don't want to have them call with mild temper elevations, because it's most likely medication. This says lasting more than four hours, or onset of fever two or more days after the misoprostol. It's much less likely to be a medical side effect.

Q So you don't see any problem with girls in this age range from 11 to 16 following these instructions without parental assistance.

A I encourage them to get parental assistance, and I have not done medical abortion on girls in that age range.

Q But the point is you – under the laws of the state of Alaska you can do medical abortions of girls in that age range, is that correct, without parental consent.

A I think that my medical judgment and my assessment of the situation and the – the girl's support team is what helps me decide what's the best procedure for her under those circumstances.

* * *

Q So we have this child 16 years or 15 years old and she just looks to have an abortion, but she doesn't have the money for the cash payment for the complications, she's going to be up the river, then; is that what you're saying, Doctor?

A That's right. If she has a complication that requires – if she needed a blood transfusion or a problem

that required hospitalization, she has to understand that's a risk she's taking.

Q And don't you agree that perhaps it'd be good to have a parent involved to. . . .

A Well, I think it's an excellent idea. . . .

Q . . . . guarantee that there would be

A . . . . for her to have an adult and/or. . . .

Q . . . . money available for postabortion complications?

A . . . . parent involved. I totally agree with you.

Q All right.

A But I don't think it should be required and I don't think it should be a parent, necessarily a parent.

Q Adult boyfriends? I mean, you want some adult to pay the bill. I mean, that's what it boils down to, right?

A We don't – I – don't go there.

* * *

Q Thank you. Now, also isn't it true that minors might not even know their own medical history, especially about events that occurred when they were very young?

A Possibly.

Q All right. And isn't it true, also, that a girl might lie to you about her medical condition in order to get an abortion, without considering the consequences of lying to you about that? Isn't that possible?

A That's a possibility.

Q And isn't it true, Doctor, that girls often misperceive that their – about their parents' reaction to their unwanted pregnancy, and often that misperception is more negative than what it actually is?

A That's true.

Q And isn't true, also, these girls often are more concerned about their parents being disappointed in them and finding out about that they're engaging in unprotected sex as being one of the reasons why they don't want their parents to know about it?

A That's one of the reasons, but as I testified yesterday, the – the people – the young women I see who are most concerned about their parents, research has shown that they have the most reason to be concerned. . . .

Q And those could be some. . . .

A . . . . but they may come from abusive family backgrounds.

Q Right. And some of those concerns may not be for the fact – they're not concerned about the parent supporting their abortion decision, but they just don't want them to know about the fact that they're getting an abortion. Isn't that true?

A They may be correct in their perceptions that they may actually get verbal or physical abuse about their discussion with their parent.

Q Isn't it true, Doctor, that when most parents find out about their child's pregnancy that they support their decision on getting an abortion?

A That's true, and that's what I tell the patient when she comes in.

Q And isn't it also true, Doctor, that these children we're talking about, again from 16 and under, are far less reliable in getting follow-up care than your adult patients?

A Not in my experience.

Q Didn't you testify in your prior deposition that that was true, and you've even noted that they have transportation problems getting there? Do you recall that, or do you want me to show you your deposition?

A No, I will say that transportation problems are an issue, but, again, we're talking about limited numbers of patients.

* * *

Q I know, Doctor, but the question is most girls 16 and under live with their parents.

A Correct, but not necessarily the ones I've seen.

Q Certainly, and there are always exceptions to every rule, isn't there?

A Correct.

Q You also agree, don't you, Doctor, that there are severe con – psychological consequences from having abortions.

A No, I do not agree.

Q You don't recall. . . .

A And I testified to that yesterday as well, that the American College of Obstetrics and Gynecology has made

that statement in their last technical bulletin about abortion.

Q Okay, let's go back to your testimony, Doctor, on page 63 of your transcript. Doctor, do you believe that there are psychologic consequences for the abortion decision?

Your answer: Yes.

Question: And do you provide your abortion patients yourself, do you provide some information about those possible consequences?

Answer: Yes, and I refer a hundred percent of them to counseling. Now, does that refresh. . . .

A Correct.

Q . . . . your memory?

A Yes, and your question this morning was severe or serious psychological consequences, and I can't agree to that.

Q All right, so you're just saying that the degree – you disagree as to the degree of consequences where – you agree there are psychological consequences, right?

A I – as I. . . .

Q Are you. . . .

A I said that the psychological consequence that most women feel after abortion is a sense of relief.

Q Do they need counseling for their sense of relief, Doctor?

A No, if they're ambivalent at all about the decision I encourage them to get counseling, and, in fact, I've refused to do abortions on women who are ambivalent.

Q Doctor, do you – don't you recall your testimony, you refer a hundred percent of them to counseling? Is that true?

A I offer a hundred percent of them counseling referral. That's my standard description of the service offered.

Q And do you. . . .

A Right after I've offered them the – explained the other options. . . .

Q Right, and do you. . . .

A . . . . so if they have any doubt about their decision whatsoever, that they understand that they can go see someone else to discuss it with.

Q All right. And, Doctor, don't you believe these 16-year-old girls and under who get abortions should have some counseling afterwards?

A No, not necessarily. That's their decision with their adult or whoever they have chosen to confide in.

Q Wouldn't you recommend to the girl to get counseling after she had an abortion?

A No, not after she had an abortion. If she came in and was having problems, I would recommend that.

Q You agree, Doctor, that the – suicide is the third highest cause of death for teenagers? Are you. . . .

A I would be not surprised. I'm not able to pull that statistic out myself.

Q And don't you agree that it's important to monitor 16-year-old girls and younger for possible depression after abortions?

A Yes.

Q And it's important to have parents aware of that potential problem?

A Or another concerned adult.

* * *

Q Wouldn't you agree that one of the most important factors in the risk fac – of delivery is the quality of prenatal care a woman is getting?

A No, I wouldn't say that. In terms of – some women come in without any prenatal care and have absolutely normal deliveries. When they've tried to increase and encourage, particularly inner city women, to receive more pretal [sic] – prenatal care, they have not been able to improve the complication rate. There's – we've been very mortified by our inability to affect, for example, the preterm delivery rate, which is the – one of the major complications of pregnancy in the United States. It's remained constant over about the last 50 years, despite all of our advancements in prenatal care, and that's one of the most important indicators of neonatal and – mortality and morbidity.

Q You would agree, wouldn't you, Doctor, that good prenatal care is always in the best interest of a minor girl who's pregnant; is that correct?

A Yes, I would agree to that.

Q Would you also agree that having abortion may or may not be in her best interest?

A No.

Q So you think an abortion is always in her best interest, Doctor?

A Well, I'm sorry, if we're playing little semantic games, it may not be in her best interest.

Q All right, thank. . . .

A That's my job as a doctor, taking the history and doing a physical exam, to offer my professional judgment and, you know, make sure that she understands the risks pro and con to any of her decisions.

Q So the answer to my question is an abortion may or – may not always be in the best interest of the minor child.

A Correct. Or – no, I'll – I'll stop there. Sorry.

Q Thank you. Now, you've indicated that you're concerned about the – an in – possible increase in illegal abortions if this parental consent statute goes into effect. You testified to that; is that correct?

A Right, and other experts have testified to that, and, in fact, that was. . . .

Q Doctor, just answer the que – . . . .

A . . . . one of the concerns of the. . . .

Q Just – Doctor, can you just answer the question? You. . . .

A That is a. . . .

Q . . . . testified to that.

A . . . . possibility.

Q Yeah. Now, do you have any studies which support such a finding in states which have parental consent studies – parental consent statutes in effect? Do you have any evidence of that? And if you do, tell me about it. What study?

A No, I don't have any evidence from that study. I do have information af – even after Roe v. Wade illegal abortions continued to occur, because women were so concerned about confidentiality.

Q Doctor, you don't have any studies showing that there's been any increase in illegal abortions in states that have parental consent statutes in effect; isn't that true?

A That is true.

TESTIMONY OF DR. HENSHAW

Q Okay. And how many women under 15 have abortions performed after eight weeks, compared to women of other ages?

A Okay. After eight weeks – 60 percent of under 15s have their abortions after eight weeks, compared to 52 percent of women 15 to 19, and 40 percent of women 20 and over. This information comes from the tabulation of abortion data by the Centers for Disease Control, which is among our exhibits here.

Q Okay. Can you turn to – it's in the black binder number 4 – Exhibit 145?

A Yes.

Q Is that the document you're referring to?

A This is the document, and the relevant table is table 16 of this document.

Q Okay. And what page is table 16?

A Page 27.

Q Thank you. And how. . . .

A I had to calculate some of these percentages myself, but the raw data are there.

Q And how many teenage women obtain abortions after 12 weeks, compared to women age 20 and over?

A Well, these are, again, my calculations from this table. Twenty – 25 percent, one-fourth of the abortions to women under 15 were past 12 weeks, 17 percent of the abortions were women 15 to 19, and 11 percent of the abortions for women age 20 and over.

Q And in your – from your professional experience do you have information on the reasons minors – when minors get their abortions and why they tend to get them later?

A Well, based on the study I referred to before, why women have abortions, the main reasons were, first, as I mentioned, not wanting to consult other people that they might be pregnant. Another reason is the time required to make arrangements to get the abortion; that is, the travel, getting the money together, and finding where to go and making appointments.

* * *

Q Okay. In a minute I'm going to get to ask you – like you to describe to the Court a little bit about that study, but first I'd like to get your opinion on who minors involve when making their decision to have an abortion.

A Well, they of – I think that my best information would be from the study.

Q Okay.

A And we can look at table 8, and there are different meanings of involvement. You can discuss the decision, or you can get help or – from a person, or you can just inform and discuss the issue with a person. In this table we report the results of several questions: people trying to persuade them, people helpful in the decision, people accompanying them to the clinic, people helping to pay.

Q And your research, what did your study find about who minors consult when making a decision whether to have an abortion?

A Well, the people most helpful were the boyfriend and the mother and friends.

Q Okay. Did most minors involve their parents in their decision?

A Well, most minors said that their parents knew about the pregnancy and the situation. Sixty-one percent of all the minors in this study which were under age 18 said that their parents – one or both parents knew they were pregnant.

* * *

Q What were some. . . .

A Yeah.

Q . . . . of the negative consequences that they feared.

A Well, shall I read down the list?

Q Yes, if you could just read some of the percentages, please.

A They didn't want to hurt or disappoint their parents, 73 percent. Thought the parents would be angry, 55 percent. Didn't want the parents to know they were having sex, 32 percent. Thought parent would try to make them stop seeing their boyfriend, 32 percent. Parent has too much stress already, 25 percent. Didn't need parent to help me decide what to do, 23 percent. Thought it would cause problems between parents or between parent and stepparent, 20 percent. Thought parent would make me leave home, 18 percent. Thought I would be punished in other ways, 15 percent. Thought parent would try to make me continue the pregnancy, 14 percent. Thought I would be beaten, 6 percent. Thought parent would try to make me have an abortion, 5 percent. And others – other cons – reasons were given by 12 percent.

Q And in the study did you look at the actual reactions of parents to the news of their daughter's pregnancy?

A Well, the daughter's description of the reactions, yes.

Q And according to the daughters how did the parents react to the news of their pregnancy?

A Well, a lot of them – there's a table here. Let me just look at the table. Maybe there isn't a table. About equal proportions were – had – were supportive. I mean, they were not happy, but, generally speaking, the parents were supportive of the – the daughter in her time of trouble.

Q And was there any difference in reaction between – of the parents between the minors who voluntarily told their parents and those whose parents found out a different way about their pregnancy?

A Yes. The minors whose parents found out a different way were predominantly angry and had – had much more negative reactions to the fact.

Q And what sort of negative reactions did they have?

A Again – well, I don't remember exactly where we reported that, and I'm not sure I remember the details too well, but. . . .

* * *

Q Okay. Let me draw your attention – this is a document that's attributed to the American Academy of Pediatrics. Are you familiar with that organization?

A Yes.

Q And apparently approved by the Council on Child and Adolescent Health. Are you aware of that organization?

A No, but I understand that most of these associations have subgroups concerned with different particular topics.

Q Okay. Sir, if you'd turn to page 2 of that document, please, and can you see the paragraph that's marked voluntary parental involvement?

A Yes.

Q Okay, in the second column there?

A Yes.

Q The third sentence, could you read that to us, please, that begins with survey.

A A survey of 1,519 unmarried pregnant minors in states where parental involvement is not mandatory found that 61 percent told one or both parents about their intent to have abortions.

Q Okay. Now, sir, if you look there there's a footnote. Actually, it's after the next sentence. And if you look in the back, footnote 19, on the last page, that's a citation to your study that you've been testifying about; is that not right?

A That's right.

Q Okay. And it's correct, Dr. Henshaw, that you never said in that study or as a result of that study that 61 percent of the minors in your study group told their parents about their pregnancy and desire for an abortion.

A No, 45 percent told their parents, and the rest – in the rest of the cases the parents found out some other way.

Q Okay, so their statement in this authoritative article here that a study of 1519 unmarried pregnant minors in states where parental involvement is not mandatory found 61 percent told one or both parents about

their intent to have abortions, that's incorrect; isn't that right?

A It's not completely correct.

Q It's. . . .

A Right.

Q Is it. . . .

A It's – it's incorrect.

Q . . . . not, sir – it's entirely incorrect, is it not?

A Yes.

Q Okay. Now, sir, as a responsible social scientist, especially since they cited your study, had this been peer reviewed do you think you would have made some comment or change to this document?

A I would, yes.

Q And especially if you knew that this document was going to be relied upon by professional obstetricians and gynecologists. Correct?

A It doesn't matter. I would try to make it a correct statement, regardless of what the purpose was.

Q Okay, sir. The next sentence there, could you read the next sentence that begins with the younger?

A The younger the minor, the more likely she was to do so: 90 percent of those 14 or younger, 74 percent of those 16 years old.

Q Okay. And, again, there's a citation there to your study. Now, sir, is that a correct statement of what your study showed?

A It's not technically correct. I – I think most people reading it wouldn't really make the distinction between whether the minor told the parents or whether the parents found out. I think that the point was probably correct, that the parents knew. They should have phrased it in that proportion of the cases the parents knew, but in fact for the four – under 14 it was more likely that the parents found out some other way than that she told them.

* * *

Q And did your study – at least in the printed analysis you put in your study that 11 percent of those minors said their parents were making them have an abortion?

A Yes.

Q Okay. Now, abortion providers don't provide abortions unless the patient wants one, right?

A That's right.

Q So. . . .

A Unl – well, unless the patient freely decides that that's what she wants, yes.

Q Okay. So you're saying 11 – let me go back here and just set the stage, so we understand. These questionnaires were handed out during about a six-month period at abortion clinics that do several hundred abortions a year to minors who were there for the purpose of getting an abortion.

A Correct.

Q Okay. And so 11 percent of those – actually, 11 percent of the 16 percent of those minors whose parents found out on their own.

A No.

Q It's 11 percent of the total?

A It's 11 percent of all those whose parents knew. Eighteen. . . .

Q Okay.

A . . . . percent of the minors whose parents found out said that they were being forced to have an abortion.

Q Eighteen percent.

A Eighteen percent.

Q And did they get abortions, do you know?

A Yes. These are all people who got abortions.

Q Okay. The question number 7 – or response 7 in your request in 25 here was the health of my parents has suffered. Did you explain anywhere in your questionnaire what you meant by health of my parents?

A No.

Q Number 11 – well, let's go to 9. It caused problems between the parents I live with. Did you explain anywhere or – for the respondent what you meant by problems?

A No.

Q Physical violence in my home, there was physical violence in my home, qu – answer number 10. This is one

of the responses on which you based your conclusion that a lar – a certain percentage of these minors were subject to violence in the home because they had – their parents had found out, right? I'm referring to. . . .

A Yeah, yeah.

Q . . . . question 10 – or response number 10.

A We didn't assume that the minor was – was the target of the violence.

Q Okay. Did you define anywhere what violence was?

A No.

* * *

Q Okay, and we talked about this yesterday and so on. Doctor, if you look at page 203 of that – I'm sorry, would – yeah, would you turn to 204 first, please? And next to table 7 the second column there, there's a paragraph that says be – that begins by the time of the abortion. Do you see that one, sir?

A Yes.

Q It says only seven percent of the mothers and eight percent of the fathers still wanted their daughter to continue the pregnancy, and this is percentages of parents who knew about the abortion; is that correct?

A That's correct.

Q Okay. So if we do subtraction, then, that's basically saying, is it not, that 93 percent of the mothers, 92 percent of the fathers who were aware of the abortion – of the pregnancy were in favor of abortion by the time that

the child reached the clinic and filled out this questionnaire, correct?

A No, sir. There were a certain number where the opinions of the parents were unknown to the minor. The ones where the minor knew – it's approximately correct, but I think it may not take into account the unknowns.

Q Okay. But it doesn't say that there, does it? It doesn't indicate in that sentence I just read that there's some other numbers out there.

A It says that seven percent of the mothers, and when you say the mothers it might have included those in the denominator where the minor did not know.

Q Okay. Well, Doctor, isn't it. . . .

A But – but that's – that's approximately correct.

Q Okay.

A That's approximately correct.

Q We can agree, then, that it's a very high percentage of the parents who knew about the abortion favored the child's abortion by the time they got to the clinic, right?

A That's correct.

Q Now, Doctor, isn't it true that in your study here on this document that you found that the parents were more likely to be angry or upset if they found out on their own about the daughter's pregnancy and desire for an abortion, rather than if they were told by the child?

A That's correct.

Q And you also said, did you not, in this article that this may reflect the disappointment of those parents who were not told that their daughter had not told them; is that correct?

A I don't recall that line in – in the article.

Q Okay, would you look at page 203, please?

A Yes.

Q And the sentence beginning at the bottom of the second column just above the table, and you cited – you quoted the first part of this in your direct testimony, and I'll just read it to you. The more negative reaction to parents who found out may reflect the correct judgment of the daughter who avoided telling them. And you told us about that in direct testimony, right?

A That's right.

Q Okay. But then the sentence goes on to say it may also reflect the parents' disappointment that their daughter had not confided in them.

A That's. . . .

Q Is that correct?

A Yes.

* * *

Q Doctor, isn't it true that your testimony is attempting to extrapolate the results of this study to the future of minors in Alaska?

A Yes.

Q And isn't it also true that the law we're talking about here, the parental consent law in Alaska, would involve minors 16 or younger, and not minors 17?

A That's correct.

Q Doctor, would you agree that minors are susceptible to adult influence in a lot of their decisions?

A Yes.

Q Turn to – if you turn to, please, table 8 on page 205, and if we look at the column of those headed tried to persuade respondent to have an abortion, and if we look at the column where neither parent knew, isn't it correct that for those minors who are under 16, in the column under 16, whose parents didn't know about their pregnancy, that 36 percent of the time their boyfriends tried to persuade them to have an abortion?

A That's correct.

Q Would you also agree from that table that the boyfriend was involved in the decision of the minor who was there for an abortion over 90 percent of the time for all of the minors in your study?

A For all of the minors in the study?

Q I'm sorry, all of the minors under 16 – 16 or un – pardon me. All of the minors under 16 in your study.

A Do you mean the minors for whom neither parent knew?

Q Correct.

A Involvement doesn't – in this table doesn't mean involvement in the decision. It means involvement in

decision or arranging the abortion. So the 93 percent of boyfriends included those who may have had no role in the decision, but accompanied the minor to the clinic or helped pay for the abortion or helped in other ways. So in. . . .

Q Okay.

A . . . . terms of – we don't know for sure that they were involved in the decision.

Q If they accompanied the minor to the abortion clinic you didn't consider them involved in the decision?

A I wouldn't necessarily.

Q Okay. But isn't it true, and I thought that was my question, that for those minors under 16 your data shows that a boyfriend was involved in their decision over 90 percent of the time?

A I tried to explain the boyfriend was involved in the decision or in making arrangements. . . .

Q Okay.

A . . . . for obtaining the abortion.

Q All right.

A Or by accompanying the minor.

Q Doctor, in that same table, and I think you testified to this before, about the number of minors in your study who had consulted a professional before arriving at the abortion clinic, and is it not true that only 22 percent of those minors 16 and under had consulted some professional before coming to the clinic and filling out this survey?

A That's correct.

Q And isn't it also true that more minors consulted a professional if their parent knew of their pregnancy than did those minors whose parent did not know?

A That's true. The difference is small, but that's true.

Q It's like six – four percent; is that not right?

A That's right.

Q Doctor, you had data, did you not, when you did this study or after you did it where you could show how many of the boyfriends involved with these minors were over – 21 years of age or over, correct?

A That information for almost all the boyfriends is in – in the data set.

Q You didn't put it in this published study, did you?

A No.

Q And, Doctor, you have stated in the past, have you not, that you don't think prosecution of statutory rape is particularly beneficial to a minor; is that correct?

A That's correct.

Q Doctor, going back – I think we're through with this study for a moment, but going back to the memorandum from yourself to Dr. Forrest, number 2243, we talked about yesterday, I'm just going to ask you a general question about it. Is that the kind of a memo that you regularly use to communicate with your superiors on studies of this kind?

A Maybe you could explain the question a little more. I think that that was – I don't know what you mean. There. . . .

Q Okay, it. . . .

A . . . . there are other – let me try to answer your question. There are other occasions when I wrote memos about information that might be related to whether we should do a study or not. That's true.

Q Okay. So this was kind of a regular thing. You didn't make a special effort to put a memo – to send a memo to your boss just on this one study idea.

A I didn't do this very often, that's true, but I'm sure it happened at other times that I would write memos.

Q That you would communicate in writing, rather than face to face?

A Yes.

* * *

Q And isn't it correct, Doctor, that in this article you stated that in 1994 about 47 percent of women in the United States who had abortions that year had had at least one before?

A I'm sorry, what percentage?

Q Forty-seven percent.

A That's – that sounds correct.

Q Okay. And, in fact, if you look at page 5 – it – it's numbered 5 at the bottom. It's 15 at the top.

A Right.

Q And it has a section on repeat abortions?

A That's correct.

Q And, Doctor, is it also correct that you stated that Canadian statistics show approximately 25 percent of teenage abortion patients will have another abortion within the next four years; is that correct?

A That's correct.

Q And, Doctor, if you look at page 8, please? And the paragraph – first par – full paragraph on that page, isn't it correct that you stated that the delay among younger women in obtaining abortions probably reflects their inexperience in recognizing the symptoms of pregnancy; is that right?

A That's correct.

Q Their reluctance to accept the reality of their situation; is that correct?

A Yes.

Q Their lack of knowledge of where to seek advice and services?

A Yes.

Q And their hesitation to confide in adults.

A Yes.

Q And you stated adults, not just parents, correct?

A Yes.

Q Now, Doctor, on page 10 of this article isn't it correct that there is no complete database of complications from the abortion in the United States?

A That's right.

Q And isn't it also correct, Doctor, that you stated on page 10 that only about one-third of abortion patients return to their provider for follow-up care; is that correct?

A That's right.

Q And isn't that one of the reasons, then, why you state that there is no really complete data on abortion complications?

A No.

Q Okay. If you look at the bottom of page 10, the last paragraph there, you say the largest database of abortion complications in the United States is maintained by the National Abortion Federation, correct?

A Yes.

Q Okay, we talked about the NAF yesterday, and isn't that correct that that is a group, really, like a trade association of abortion providers?

A That's right.

Q Okay. And you go on to say in 1995 a total of 175 NAF members reported information on 241,986 abortions at all gestational ages. Follow-up information was available for 30.7 percent. Is that right?

A That's right.

Q Okay. Now, Doctor, would you agree, then, that that's one of the weaknesses of these NAF figures, is that a large number, like almost 70 percent, don't come back for their follow-up visit so they can see if there are complications, correct?

A The – most of the complications are not identified by a follow-up visit. The follow-up visit generally identifies people without complications. It's very rare that the follow-up visit is the point at which the complication is identified. The complications here are from – primarily from women who call back to the abortion provider. . . .

Q Okay.

A . . . . to – for – for care because of a problem.

Q You're not a medical doctor; is that correct, sir?

A That's correct.

Q And you haven't ever done treatment, either pre-, during or post abortion for any woman, correct?

A That's correct.

* * *

Q All right. So if we add up the 2802 that were instate minors, the 20 – the 1141 who are out-of-state minors, we get around 3900 minors' abortions, correct?

A That's right.

Q Okay. And then we go back up to 1980 before the law was in effect and we see – just excluding for a moment the numbers who left state – you have at least 5,113?

A That's right.

Q Okay. If we don't even add any more, then that's a difference of over a thousand, correct?

A Yes.

Q And isn't it also true this study didn't find any significant change in the birthrate for minors?

A The authors concluded there might have been 50 additional births. That's pretty questionable.

Q Questionable as to what?

A As to the reliability of that figure. They didn't claim it was reliable, and I wouldn't put a lot of reliance on it, but they. . . .

Q They didn't find a change, significant change in the birthrate, correct?

A They considered it significant enough to report, but I wouldn't consider it real significant.

Q Doctor, isn't it true that you could gather – or one could gather from this study that the pregnancy rate in Massachusetts went down after the implementation of the two-parent consent law?

A I – no, I – I wouldn't draw that conclusion.

Q I know. . . .

A To draw that. . . .

Q . . . . you wouldn't, sir. Isn't it possible for someone to look at this and draw that conclusion?

A I think before you would draw that conclusion you would – the conclusion would properly be drawn by looking at the trend over time, plus a comparison of the minors

to older women 18 to 19 years old, for example, which might have also been influenced by some trends at that point in Massachusetts. So you wouldn't – I don't think – I don't think any responsible scientist would draw that conclusion without much more statistical work with the data.

* * *

Q But for minors the proportion of late abortions fell with the law, while the proportion of early abortions rose. Correct?

A That's correct. I would not say that was a conclusion of the study. This is. . . .

Q Sorry?

A . . . . a find – that's not a conclusion. It's a finding. It's a result of the data she looked at.

Q Okay. So it's a finding of the study, but not a conclusion. You would agree with that.

A That's right.

Q Okay. Now, Doctor, isn't it also true that in the explanations that the author of this study gave, that the author concluded, and this is a conclusion, is it not, that more minors may have avoided pregnancy because of these parental involvement laws? Is that correct?

A If you could point to that?

Q Sure. Alternative explanations, the bottom of the same page.

A Yes.

Q It says there are several ways to explain findings that instate abortions fell in response to parental involvement laws, while birthrates did not rise. First, more minors may have avoided pregnancy when faced with the laws. Correct?

A Yes. That's – yes. They state that as one possibility.

Q Okay. Okay, Doctor, if you could go to 120 – sorry – number – Exhibit 120. And this is "Impact of Minnesota Parental Notification Law on Abortion and Birth," by several authors, the lead author, Dr. Rogers. You've seen this study before, correct?

A Yes.

Q And, in fact, did you testify about this one yesterday? I believe you did.

A Yes, I did.

Q Okay. And isn't it correct that Dr. Rogers stated in this article that for ages 15 to 17 the number of late abortions per 1,000 women decreased following the enactment of the law. Is that correct?

A That's correct.

Q And he concluded, therefore – I guess that's a conclusion, right? Therefore. . . .

A Yes.

Q . . . . s increased medical hazard due to a rising number of late abortions was not realized. Correct?

A Yes.

Q And, Dr. Henshaw. . . .

THE COURT: Counsel, where were you reading from again? I'm sorry, I couldn't find it.

MR. DOOGAN: I'm sorry. Page 4, and in the last – I'm sorry, the single column of parent – it – it's actually numbered page on the article itself.

THE COURT: Okay.

MR. DOOGAN: The column on the right.

THE COURT: Uh-huh.

MR. DOOGAN: The second paragraph at the bottom. It says: Regardless, the claim the law caused more minors to obtain late abortions is unsubstantiated. In fact, the reverse is true for ages 15 to 17. The number of late abortions per thousand women decreased following the enactment of the law. Increased medical hazard due to rising number of late abortions was not realized.

Q And, Dr. Henshaw, you've stated before, have you not, that from this study that there appeared to have been a depressive effect on the pregnancy rate because of the law in Minnesota.

A That's right.

Q Dr. Henshaw, you would agree, would you not, that if the law we're talking about here in Alaska actually reduced the number of teen pregnancies, it would be beneficial to minors?

A I think I could agree to that. That's a value judgment, but I think I would agree with that.

TESTIMONY OF DR. SHADIGIAN

Q All right. And from your clinical experience, and I'm not only speaking of the experiences at your – at Baltimore, but also the entire time of your medical career so far in dealing with these girls, do you think it's necessary to have parents involved in a pregnancy decision of whether to carry the child to term or to have an abortion?

A I think parental involvement is the key for the long-term mental and physical health of young women, for several reasons. The children are especially vulnerable. They haven't had time to go through the normal developmental stages of adolescence many times. We're talking about young ladies, especially 16 and younger, haven't fully matured into adult thinking, and therefore need the help and guidance of another adult. The obvious choice are the adults who know them best, who are their parents. So as much as young ladies are usually very afraid to talk to their parents, in fact, they're the – the single most qualified adults who know their children the best, who can actually help their children through the most critical time that they've probably ever experienced in their entire lives. So that I absolutely agree that parental involvement and consent in this decision will on the whole, regardless if abortion is the choice that is made or not by young women, will absolutely help them be able to become fully developed adults who have the least amount of scarring from these experiences.

Q Now, specifically in the area of informed consent in dealing with these girls and this age range – we're talking about from age, I guess, 10 to 16. I guess as young as 10.

A That is correct

Q From 10 to 16 – are there specific problems for a doctor in getting informed consent from a girl in this age group pertaining to any type of surgical procedure?

A As we all know, parental consent is necessary for any kind of surgical procedure under age 18 in states, so whether a young child is undergoing a tonsillectomy or having an ovarian cyst removed or having bowel surgery, parental consent is both deemed important and necessary and legal, for any kind of surgical procedure. So you can look to all other parts of medicine and see that this is considered a standard of care.

Q Pertaining to surgical procedure regarding abortion, in your – and, again, regarding your contacts with these young girls, do you believe that they are able to understand the risk and consequences without assistance in making an informed and intelligent decision in this area?

A Most young children of those ages have never had surgery themselves, they've never experienced maybe even very many periods that they've had, so when you tell women that are young women that they're going to have vaginal bleeding, they've only had three periods, they're not going to have the same kind of conceptualization of what that is, as compared to when they're older. So on something as simple and as obvious as how much vaginal bleeding is normal after certain procedures, they may just have not a lot of experience with those things. For all of the different risks, we talk about bleeding, infection, damage to the internal organs, et cetera, it may be difficult for them – they may not have had a lot of biology in school yet and a lot about human anatomy, so sometimes, just like people who don't have English as a first language,

take more time to explain things, young women certainly have the capacity to understand certain kinds of concepts, but it takes longer to explain them. Pictures are very helpful to explain to people, and – and showing them on their own bodies things are very helpful. We do that routinely with pelvic exams for young girls who've never experienced them. I take a long time explaining the instrument we're going to use and how it's appropriate to touch in certain ways and not other ways. So anyone who's just new at understanding different techniques or different procedures, it just takes longer to explain in a really full way so that real informed consent can be obtained.

Q And do you believe that parents are necessary and valuable in obtaining informed consent from girls of this age pertaining to abortion procedures?

A I do, because the parents are going to be the ones who later on – I mean, every office visit is – is a certain amount of time, and one cannot completely know everyone's medical history in that short period of time, and parents are absolutely essential in getting accurate histories, and then also with the informed consent process. They may be able to chime in and say remember when your older sister had this thing done, remember she had this problem. They can try to explain things in terms and – that younger women can understand and that relate to their daily lives even better than the physicians can.

Q Now, Dr. Lemagie testified in this case that in her clinical practice she often found that minors misperceive what their parents' reaction is going to be when they found about – find out about an unwanted pregnancy, and basically that they misperceive it in thinking it's more negative. Do you agree with that opinion?

A Yes, I do. In fact, there's research that supports that out of Yale-New Haven as well, so both in clinical experience and in – in – in research studies it's been shown that teenagers don't accurately predict what their parents are going to react about for something like an unintended pregnancy.

Q Regarding medical history, is it important to get an accurate medical history before performing an abortion on a young girl this – 16 and under?

A Not only is it important, it's essential. Any surgeon will tell you that an accurate medical history is the key to knowing exactly what people's risks are during the surgery, as well as what their postoperative complications may be. So an accurate medical history is the core foundation of not only diagnosis of medical problems, but also in the treatment arena.

Q And is it important to get an accurate family medical history prior to performing an abortion on girls 16 and under?

A Family histories are also one of those areas where there can be surprising histories that are found out. There certainly can be genetic disorders which are really only diagnosable through an accurate family history, such as excessive bleeding problems or other siblings that may have had bleeding problems that a younger girl in the family may not even have been aware of.

Q Is it important to have a parent involved in providing an accurate medical history for the girl, as well as a family history, a medical history, prior to a girl being exposed to an abortion?

A Yes.

Q Explain to the Court why this is critical information and why it's invaluable to have a parent involved.

A Many times young women may not be very aware of what their own medical history is. For example, if a young woman has an allergy to Penicillin, which is a very common allergy of an antibiotic, they may not know that that's even their allergy, especially if they've been someone who's been well for a long time of their life and so haven't – hasn't needed to go to the doctor for antibiotics for many things. So Penicillin allergies may cause shortness of breath, it may cause the whole trachea to swell up, and young women can have severe anaphylactic allergic responses, and those kinds of pieces of information are very important for physicians treating any woman to have access to, and sometimes, and this is very common in – in young women, is they'll say, you know, I was allergic to some kind of medicine, my mom told me when I was a baby, but I – I don't know the name of it, or even when you probe them and say, well, could it be Penicillin, Erythromycin, they'll just say, you know, what, I don't know. And so something as simple as an allergy is very important, especially in the setting of abortion, because antibiotics are routinely used in modern abortion procedures and follow-up to reduce the risks of infection. So if I a physician can't pick the right kind of antibiotic to help a young girl reduce infections and not to be allergic to that, it really puts the abortion provider at a real disadvantage in terms of their desire to really do the best kind of medical care for young women.

Q And what areas should an abortion provider be looking at in trying to get information from a young girl's medical history from her that's important in delivering her a safe abortion?

A Well, the regular things, such as what medications they're on. Because many times anesthesia is used with abortions, they need to know if there are going to be drug interactions between medications a young woman may be taking. Allergies we talked – talked about. Medical history, does she have a history of a bleeding disorder like von Willebrand's disease. A lot of abortion providers wouldn't think that would be safe to do outside the hospital and may want to have other kinds of blood products available. Other histories may be that the provider themselves may not understand that a woman has had a prior abortion. Even a young woman may have had a prior abortion, which may increase her risk of having scarring at the site of the cervix or have other kinds of actual surgical complications before. We can just go on and on. There's – you know, every piece of what you expect from a history taking, in a full history taking of – of all issues will be important. In addition to that, you know, something that I've talked about and all the major medical professional organizations say, are that we should be absolutely screening for violence in young girls' lives, and, in fact, teens are at the highest risk of violence. So we need to be screening for physical assault and sexual assault of young women, because they're going to be put right back in the same situation, otherwise, if they have these histories and nothing's done about it. We have child abuse laws in every state in the nation that require health-care providers to make reports about suspec- suspicion of child abuse, not to actually prove that there is child abuse, but suspicion of child abuse, which also involves criminal sexual assault in many cases.

* * *

Q Now, do you think regarding the selection of a medical provider for an abortion, is the skill of that provider one of the major risk factors on whether or not there's going to be complications from an abortion?

A Yes, there is ample data in the literature that support that statement.

Q And regarding abortion providers, is this a major concern in finding a competent provider in that particular area?

A Yes. In fact, when you look at online abortion information services, many of the online services, websites, in fact, tell young – both – anyone who would just access the website please check local medical societies for the – you know, how – how – what the physician's malpractice record may be, if they are licensed, all those kinds of things. So actually a lot of the abortion sites where there's information about abortions have different questioning lines that you can ask for different providers, so that's on a lot of different websites around the country about what are the savvy questions to ask abortion providers, both for the physician and the facility as well, and – and those kinds of pieces of information are things that teenagers may find harder to access and understand, and parents can be very helpful in terms of trying to find out the reputation of different physicians in a community, or even as many – even something as simple as asking a pro-abortion provider how many of these do you do, do you do this full time or part time, do you do second-trimester abortions, how do we know what part of the pregnancy my daughter might be in. So parental involvement will be very helpful in – in trying to understand the right questions to ask as well.

Q Does an abortion provider have to be board certified in OB/GYN?

A No.

Q Do they even have to be an OB/GYN?

A No. Most abortion providers are not ob – obstetrician/gynecologists.

Q Do they have to be surgeons?

A No.

Q Do they have any minimal requirements besides an M.D. degree in – regarding – to be able to perform abortions?

A Not that I am aware of.

Q So a podiatrist could perform abortions, then, if she – if that podiatrist is an M.D.; is that correct?

A Yes.

Q So do you believe that it's important to have – or do you think that parents would be helpful and important to a young child 16 and under in seeking out and finding a competent doctor to perform the abortion?

A Yes.

Q Do you think that's critical pertaining to whether or not a girl is going to get a safe abortion?

A Yes.

* * *

A In terms of short-term medical complications, and I'll try to zoom through this fairly quickly and I'll just

move to the next few slides because there are all the short-term things, and, again, these are things that women should know about who are having this kind of surgical procedure, and these are things that I tell all the women that I'm doing D & C's on and other procedures like D & E's who have babies that have died, are things like bleeding, infection, including abscesses in the pelvis, damage to internal organs, including the uterus, the ureters, bowel injuries, bladder injuries, prolonged retention of fetal bones has been reported in the literature, fetal parts embolization, which is where little pieces of the baby actually get in the mother's bloodstream and can go to different parts of the woman and cause problems with her heart and lungs, postabortion septic pelvic thrombophlebitis, which are clots in the different vessels going into the pelvis, risk of blood transfusions. And then a lot of women don't realize how many times they need a second procedure. Even though the first time they had a procedure the – the abortion provider did the best job they could, they still either left tissue inside requiring a repeat dilatation and curettage – sometimes we have to actually look in a woman's belly in case there are instruments that have been pushed through their uterus, and sometimes we have to actually cut the woman open completely and look inside manually, which is called an exploratory laparotomy. And then occasionally when the situation is quite grave sometimes we actually have to perform a hysterectomy and take out the tubes and ovaries, which is, again, not as common, thank goodness, but would result in loss of fertility as well. And there can be – and these are all from actual case reports, but – ruptured ovarian cysts, ectopic or tubal pregnancies that weren't suspected or they were at the same time as an intrauterine pregnancy, and then

the heart and lung systems of women can collapse sometimes because of the medications given.

Finally, pain, problems with the placenta, where it grows in inappropriately into the uterus can be complications of the procedure and cause bleeding. DIC is a special coagulopathy or situation where a woman keeps bleeding and bleeding and bleeding and it's not easy to stop without special blood products. Some reports have shown that actually women have gotten hematomas near their brain. Asherman syndrome is a scar tissue that's in the uterus from the procedure itself. Embolization is meaning that either – the fluid around the baby can get to the other parts of the mom. Women can have seizures, and then there can be several cardiac problems, including endocarditis, which is an infection of the heart, an MI or myocardial infarction is especially more common in older women, valve replacement. Tetanus has been reported in the Third World quite a bit where there are no standard tetanus vaccination programs. And then the two other quite concerning ones are the risk of maternal death and the risk of a live baby after an abortion.

Q And where do you proceed then in your lecture?

A The next thing I talk about are the short-term medical complications for maternal, and – and that would be the – the most severe one is maternal death. So the CDC actually collects data on maternal death. However, it's not required to report. No one's required to report it. In general the CDC publishes maternal death data eight years behind when the actual death occurred, and so the accuracy of the data, because it's not mandatory, and the fact that there's such a huge lag time, doesn't really help clinicians in terms of looking at trends or seeing if certain

providers are – are unsafe. And we also know that usually CDC notification is greater than 12 months for half of all maternal deaths, so even when they do report it's so far removed from the situation that it's not – it's not as good data-wise for physicians to make decisions.

Also there have been just one study in the literature, which was actually quite remarkable, that showed how many – just with a sing – single sampling, that maternal deaths are grossly underreported, with 19 previously unreported deaths associated with abortions identified for a series of seven years. That doesn't actually sound like a lot, but considering the quoted maternal death rate is only one in a hundred thousand, and if there's about 1.2 abortions done on a given year, that's an average – that's 12 maternal deaths. So if you increase that by even one or two or three deaths, it actually increase the percentage of maternal deaths enormously, because the numerator is so small and denominator so big. So this kind of data is actually very essential in understanding maternal death data in the short term after abortion.

So moving on, we also know that women who are greater than age 40 have three times the rate of maternal death. Black women and min – minorities have 2-½ times the rate of maternal death, and women who have abortions over 16 weeks of gestation have a 15 times risk of maternal mortality. So this is the kind of data I'm talking about with teenagers who delay their care having much higher rates of mortality as well. In addition, there are lists on the Web in different situations where they actually pull maternal death data from newspapers, and that's not even reported to CDC. So you can actually sometimes do better looking through newspapers in American [sic] to find out who's died from abortions than actually asking

the government, which is – is quite a bit a problem. And that – all that data I talked about does not even include the maternal suicide data which has been around since 1996.

I'm just going to move on. The – for anesthesia-related complications we know that if women undergo general anesthesia they have a 2-½ times greater risk of death than if they have local anesthesia, and that even women who have the lowest risk kind of profiles, meaning a healthy heart and no major medical problems, still probably have a one in a hundred thousand risk of dying. So that tell [sic] us that, in fact, our – our death data is very low in terms of what's reported to the CDC, and we – we knew that before 1977 infection and hemorrhage were the leading causes of death, and now we know that anesthesia complications is probably the leading cause of death. So when women undergo general anesthesia there's higher rates of hemorrhaging, almost 4-½ times, and all complications almost double when general anesthesia is used instead of – of not used. So those are the kinds of things that – that women need to be aware about when they're making choices of not just to have an abortion, but what kind of anesthesia they need to have or – or don't need to had [sic].

Q All right, and that – does that summarize, basically, the short-term abortion risks we're talking about?

A Right, so those are the short-term medical compli-___. cations of abortion.

Q And then you go into in your lecture to the medical students and the doctors long-term medical complications from abortions that they should be aware of?

A Yes, long-term medical complications are the things that are actually harder to figure out in terms of wher you read the literature, and also when you look at what the American College of Obstetricians and Gynecologists says, and, in fact, when you look at abortion provider technical manuals, which are supposed to tell providers exactly what's the state-of-the-art information, these are the things that are difficult to glean, but if you actually go to the literature itself, which I have done, we found that breast cancer is higher in women who choose abortion. There are several pregnancy-related issues that are higher. Some studies show more of an effect than others in ter – in terms of ectopic pregnancies, placenta previa, where the placenta, which is the connection of mom and baby, grows over the cervix. It necessitates surgical intervention such as a C-section. There can be infertility, fetal loss in terms of preterm deliveries, low-birth-weight babies. That – we know that when we don't screen for child sexual assault, that that continues. Many times we put children right back in the same situation, and so the long-term complications of that then continue to go on unabated, and then the most sort of shocking and · and newer data is about maternal suicide in the year following abortion.

So in terms of the long-term medical complications for breast cancer, the slides you see here are ones that I've used for awhile, but when I did my new literature review I'm going to add one more thing. You have it in – in the exhibit of my preprint of my paper. But breast cancers increase for two reasons. One is women do not have the full protective effect of a full-term pregnancy to prevent further breast cancer, and this is true if a woman has a full-term pregnancy before they're age 35. That's a protective effect

against breast cancer, and you lose that when you have an abortion instead of a – a full-term pregnancy.

And then a second effect is an independent effect which is seen regardless of a full-term pregnancy or not, but a woman undergoes an induced abortion, there's an independent effect of increasing of breast cancer risk, and that was seen by both Dr. Brind and myself. Dr. Brind's publication showed an odds ratio of 1.3, meaning about approximately a 30-percent increased risk, and mine was on the same magnitude, and this would be whether a woman had the abortion at any time in their reproductive lives, or if they had the abortion before a first full-term pregnancy the numbers were slightly higher. So breast cancer has certainly been a controversial long-term effect, but I think with the new paper you're going to find out that it seems a lot less controversial.

Other pregnancy-related long-term medical complications include two papers that show an increased risk of ectopic or tubal pregnancy. That is actually a kind of pregnancy that puts a woman at risk for maternal death, because of [sic] a tubal pregnancy ruptures inside a woman they can hemorrhage to death, and that still happens across American [sic]. In the year 2003 women still die from undiagnosed ectopic pregnancies, but when women have one or two or more induced abortions the – their rates of tubal pregnancy are higher in some studies, and I quote two of the studies of that.

The other thing you'll find in my slides is when I have given this talk in the past I use the – the book – it's called A Clinician's Guide to Medical and Surgical Abortion, and that's also referenced in some of my other studies. That book is considered – well, I call the bible for abortion

providers. That's what most abortion providers rely on for the most up-to-date information about how to do abortions, what the complications of abortions are, and it turns out that a lot of the studies that I quote throughout this paper don't even show up in that book, so that there's an omission of data even to the people who are supposed to be providing the abortions in a safe and – and expertise kind of way. So if you see a few of these mentioned, it's because they're not mentioned in what you'd consider – the big professors in the country who – who know how to teach this material the best, they decide not to include this kind of material in their books.

The other long-term medical complications include the placenta previa, which I've sho – which I discussed. In fact, all of the different studies have shown an increased rate of placenta previa. That doesn't surprise a lot of people, because when the cervix is opened there can be some damage around where the cervix is opened in the uterus and there can be scar tissue and – and it may make it so that the placenta doesn't appropriately implant in the uterus in the right places. So three or – three different studies have shown this increased risk.

There have been a couple studies that show secondary infertility increases when a woman has an induced abortion, and some – there are other studies that have not shown that, so I try to present the data that – that – that shows that in – in the literature. In the new paper, however, we show all the ones. We did a whole new literature search.

Finally, both preterm delivery or subsequent fetal loss is increased as a long-term medical complication, and low birth weight, which is also a marker for preterm delivery,

is higher in women who've had induced abortions. So what that means is that we can see that women who decide to abort their babies may have a very early birth for the next one. This incurs higher risk and neonatal intensive care units, and – and surprises many women who may have thought that they weren't at higher risk because no one had told them about that.

The last two long-term medical complications is that unreported – if – if girls and children are not screened for sexual assault, they do not have the protections of the state, and they will go right back to the situations that will force them to get – have risk of being pregnant again. So the – the new analysis, this has been published since I wrote it on here, but Maureen Phipps, Dr. Phipps, was at the University of Michigan as a Robert Wood Johnson fellow in the year 2000, and she has gleaned the data from the CDC and showed that as a group teens under 15 have the highest abortion ratio. That's just straight off the CDC. And the '96 data analysis shows that 58 percent of these teens are probably pregnant from incest or rape. So by not screening the very youngest of the girls we're missing these girls having been raped and incestuously abused. So we know that – this is nothing new, but health care providers, which do include abortion providers, should be reporting suspected child sexual assault, and that has not been happening as a rule.

Finally, long-term medical complications include maternal suicide. In 1996 there was a Finnish study by Gissler showing that women who underwent induced abortion in fact had a six times higher rate of killing themselves in the year after their abortion did the – compared to the women who actually went to term. So compared to other women who were never pregnant it was

three times higher, and compared to women who had a full-term pregnancy it was six times higher. So that was shocking data. It was not included in the guide to clinicians – the Guide to Medical and Surgical Abortion, even though that book was published in 1999 and the study was out in 1996. So it – it draws concern about that.

In addition, there have been data now in America about the increased rate of both suicide and also homicide in women who've had induced abortions, that there actually – deaths from all causes that are violent are much higher in women who've had induced abortions, and suicide risk is of the same level, which is about three times higher, and this is from California data and medical records, and these are numbers that are not small. These are numbers where we look at 170,000 women and we see a threefold increase risk.

Finally, the psychological complications include that we have harder times understanding the psychological part in terms of rates of depression, in rates of different diagnoses, but the easier part of that are how do we count numbers better. So the two areas we can look at numbers very well is looking at how many women are actually admitted to the hospital under psychiatric diagnoses, which is an actual hard number, and the second thing is how many women actually have depression which can be measured by scales. So psychiatric admissions are higher for women who've had abortions, and there are two studies I quote on that, and also other diagnoses such as psychosis are higher.

* * *

Q And at that time – during her testimony did she state: It appears that women who have full-term pregnancies

have an increased risk of breast cancer for some time after that pregnancy?

A Yes.

Q Is that an accurate statement?

A It's misleading.

Q Explain to the Court why this is a misleading statement?

A There have been several studies since 1970 showing that a first full-term pregnancy before age 35 actually gives a protective effect against breast cancer. That's been established by McMahon starting in 1970. This is part of – the National Cancer Institute has adopted this as what we understand about breast cancer. So what Dr. Palmer said was actually in complete opposition to what's been established and is accepted by the medical community in terms of risk factors or protective effects about breast cancer. She said the opposite.

Q And so from a standpoint – when a woman has a pregnancy she – and – she does not have an increased risk of developing breast cancer from having a pregnancy; is that correct? From your understanding of the literature.

A That's corr – correct, that there is a protective effect of a first full-term pregnancy, especially before age 35, in reducing breast cancer, yes.

* * *

Q And, Doctor, based upon your research and your interviews with your colleagues, have you formulated opinions regarding the quality of care that these girls get when they go to abortion clinics?

A Yes.

Q And can you tell us what your findings are and what your opinion is in that area?

A When I ask my colleagues how much time they spend taking histories and doing physicals before procedures are done on people, I've noted that there seems to be great divergency in what's done in a surgery clinic or an obstetrics and gynecology clinic prior to surgery, and what's done in an abortion clinic prior to surgery. For example, it's standard practice around the country for most of the time for the actual surgeon doing a procedure to take a history and perform a physical exam and, in fact, go over the informed consent for a procedure with a patient directly. Now, sometimes that's done in a teaching situation where an attending doctor or faculty doctor will supervise a resident doctor in these situations, but in general most surgery is actually performed by a surgeon who has a prior relationship with the patient and who's gotten to know their history and physical over a period of an office visit, and whose nurses also participate in explaining the procedure as well, so it's a team approach, but the head of the team is the surgeon themselves.

At the abortion clinics it seems from talking to the actual providers, from looking through data on what women who've experienced abortion had to say and, you know, looking at quality assurance data, that it seems to be that the standard is not that the surgeon actually does the history and the physical and the consent for procedures, but, in fact, that the abortion surgeon merely reviews briefly what others have taken as a history, a physical, if there is a physical done, and what the consent may have had, so that the surgeon in this case doesn't

have the same kind of familiarity with the person – of the person who's there. They just don't really get to see them face to face before the procedure.

* * *

Q Besides the counseling services, do you – does your research reveal any concerns about the aftercare and postprocedure follow-ups that abortion clinics follow?

A Well, what was also very odd about the abortion counselor is that, in fact, they're supposed to sometimes be present during the procedure itself, and then to go over what the postabortion complications might be or go over different kinds of postoperative issues, both in the center itself that performs the abortion, as well as answering the phones later on.

Q And regarding the procedures they have as to follow-up with patients after they receive the abortion, did you find any areas of concern in that area?

A Well, it turns out that most – whether they're young girls or – or older women, most women don't go back to their abortion providers for care. In fact, 30 percent or less do. And it turns out even when it's not abortion care, young teenagers rarely follow through on medical advice when it's given, and there's good data in that in the medical literature as well, whether it's applying to abortion or not, in terms of teenagers.

* * *

Q Doctor, in your opinion does abortion carry a greater or less – or not a – less risk regarding mental health after delivery? Mental health of the child.

A Oh, the – especially looking at the suicide data, it's much less in terms of mental health effects on a woman who goes to term than someone who aborts their pregnancy, but also when you look at depression, posttraumatic events, et cetera, and psychiatric admissions, all those point that a term childbirth is much more protective of mental health than – than abortion is.

Q And you cite in your expert report the Gissler study; is that correct?

A That's one of them, yes.

Q And what does the Gissler study show?

A Gissler, to remind everyone, was a 1996 study that showed as compared to women who go to term, women who abort their pregnancies have a six times greater chance of suicide in the year after that decision, and it's three times greater than the general population of suicide rate for women who abort their pregnancies.

Q Doctor, in treating postabortion complications, in your practice do you require parental consent or is it required for parental consent before you can get postabortion complication treatments to a minor?

A Yes, we can – if – if a child's the one who's receiving the care, children need to be – you know, children's surgery has to have parental consent; that's correct.

* * *

Q Counsel referred to the American Cancer Society's position regarding the – this – their position that there was no risk – insufficient evidence at this time to find a risk regarding abortion and cancer. The question I have, is

that position that they stated, that is a position that was before the NCI's recent change in position on that; is that correct?

A That's right. All the big organizations are now changing their positions because of this data that's come out, not my personal data, but just the other data in the literature.

Q And the American Cancer Society does risk – list as a risk factor the protective effect of a first pregnancy; is that correct?

A That's correct. People have to remember that the whole point of this breast cancer abortion thing is there's two mechanisms, one that is completely undisputed, and that's that a full-term pregnancy reduces the risk of breast cancer later in life if it's before age 35, and the second part – this is all the controversy kind of stuff going on – is this independent effect of induced abortion giving slightly higher rates of breast cancer. So there's two effects. Women need to know about both the effects, and – and the more controversial one is – is – has lower numbers, basically.

TESTIMONY OF DR. STOTLAND

Q And does your opinion – does that mean that you believe that parental involvement in a minor's decision whether to have an abortion is a bad thing?

A No.

Q Can you explain that?

A Well, if – what seems to be most helpful to people is if they can consult with the people they think will be most helpful to them, and for most adolescents, most minors, the – their parents are those people, and their parents can be extremely helpful to them in making decision and in carrying it out.

Q Do you think that encouraging parental involvement is helpful to a minor considering an abortion?

A Yes.

Q Okay, and do you think that the law – the Alaska parental consent act encourages minors to consult their parents for an abortion?

A Well, it requires them to get their parents consent. It doesn't say anything about what kind of conversation there is or whether the parents, you know, are helpful. It simply allows the parents to veto the decision if they wish to.

* * *

Q Okay. If you'll look at the last paragraph, Dr. Stotland, isn't it correct that Dr. Adler says: Although women in general show few adverse effects of abortion, it is possible that adolescents are at increased risk compared with adult women, and that their risk is great enough to require added protection.

A Are you asking me whether I agree with that?

Q Well, first of all, you see what I'm talking about here?

A Yes, yes.

Q And you acknowledge, then, that's Dr. Adler's opinion at the time she wrote this article. . . .

A Yes.

Q . . . . correct?

A That it was possible.

Q Correct. And do you agree with that?

A Many things are possible. I think if you look at the whole article you'll see that she doesn't think it's very likely, but it's possible, and I think it's part of good science, quite often, to allow that many things are possible, and to have an open mind.

Q Doctor, do you agree, also, that Dr. Adler said more research is needed on adolescent competence and decision making? And I refer you to page 294.

A That's another thing that's said in almost every scientific article, that more research is needed.

Q Okay. Dr. Stotland, it's your opinion, then, that more research is not needed on the psychological consequences of abortion or the psy – the ability of minors to make abortion decisions?

A Well, I have to answer that – I have to give two answers to that. One is it's always advisable to have more research on important issues, but I think there's enough of a body of – and – and also it depends for what purpose. For purposes of making social policy or laws now I think there's enough evidence to make decisions about that, but of course it's always useful to have more research.

Q Doctor, isn't it correct you were willing to make decision about that back in 1991 when you testified in California with the state of the research at that point, correct?

A I was willing to – I was willing to do what exactly? I'm not sure. . . .

Q Well, Doctor, you. . . .

A . . . . what you're asking me.

Q . . . . gave an opinion that the California parental involvement law was contrary to the best interests of minors in that state, correct?

A I would have to look at my testimony, but yes, that's probably what I testified.

Q All right. And you testified about that based on the state of the science on the psychological consequences to minors of abortion and the decision-making ability of minors to decide abortion as it existed back prior to 1991; is that correct?

A That isn't the only basis I – for my opinion, but it was that time, and that's as much scientific evidence that – as we had at that time.

Q Okay. Doctor, getting back to the necessity for a minor facing an abortion decision to have strong social support, you agree, do you not, that most often it's that minor's parents who can provide that kind of social support?

A Yes, I agree.

* * *

Q Okay. On page 780 where it says relations among outcomes, I believe you said that – and please correct me if I'm wrong – that most of these – in this sample most of these women were neither dissatisfied with their abortion decision or depressed two years later.

A Yeah, 6.2 percent were both dissatisfied and clinically depressed, and 65 percent were neither depressed nor dissatisfied.

Q Okay. So the 6.2 percent dealt with those who are both unhappy with their abortion decision and also depressed, correct?

A Yes.

Q All right. So we can conclude from that, can we not, that 35 percent of this sample were either dissatisfied with their abortion decision or depressed two years later, correct?

A Yes.

Q Okay. And is it correct that Dr. Major found that of her sample 17 percent had suffered postabortion medical complications, including abnormal bleeding and pelvic infection?

A Seventeen percent reported that they had, yes.

Q Okay. And do you believe they had any reason to not tell the truth?

A Well, I don't know what kind of bleeding, for example, they expected, so what is meant by abnormal bleeding may be more than a menstrual period, or whether they meant more than is normal after an abortion, so they

just might not have – I don't know what degree of information they had.

Q Okay. And, Doctor, isn't it correct that Dr. Major found younger women evaluated their abortions more negatively?

A Yes.

Q Okay. And if you look at page 781, which is the next page, and I think you testified about this, would you agree that the study found that one percent of this sample had posttraumatic stress syndrome associated with abortion? Is that her finding?

A Yes.

Q Okay. Now, isn't it correct that you don't agree with this finding?

A No, it's. . . .

Q Okay.

A . . . . not correct.

Q All right. Doctor, is it your opinion that abortion does not cause posttraumatic stress syndrome in any woman?

A They – associated with isn't' the same as caused by, and it also depends on the – on circumstances of the abortion. I can certainly envision, and I know of abortions performed under circumstances that would cause or be a possible precipitant of PTSD.

Q Okay. Doctor, if it were true that this one percent was due to the abortion, would you be concerned for those patients?

A I'm concerned for anybody who has a disorder.

Q Okay. So you would consider it significant, then, a finding that one percent of the abortion patients in a sample this size had posttraumatic stress syndrome associated with the abortion.

A Well, I – what do you mean by significant?

Q Well, Doctor, isn't it correct that Dr. Major found it significant enough to put this statement in her study?

A Yeah, and she – in – in the context of comparing it with the rate in the general population, which was 10 times as great.

Q Uh-huh. But none of those in the general population she was talking about were not the people who had abortions in her sample, right?

A The – the general population is the general population that's been done in – determined in population studies, so we don't know whether they – what – what they were – what the trauma was that precipitated their PTSD. Many people who have abortions or people who have – among people who have abortions the rate of victimization and violence having had – being the victim of violence and other forms of abuse is higher than in the general population, and – and those things predispose to PTSD, and having a previous PTSD pre – predisposes to having more PTSD. So if you mean by significant that I would think that abortion in general leads to PTSD, both what I've just cited and the fact that it's much less than in the general population wouldn't lead me to think that it's significant in terms of a cause of morbidity among women contemplating abortion or having abortion.

Q Okay. Doctor, isn't this statement in Dr. Major's study consistent with the conclusion that one percent of her sample had PTSD because they had the abortion, whereas the general population of women in this age group not having had abortions had a higher rate?

A No, they're a lot – first of all, she says associated with. She doesn't say caused by. Secondly, we don't know – many women in the general population have had abortions, so. . . .

Q Okay, well, Doctor, isn't it correct that Dr. Major – we'll quit with the semantics in a moment, but – that had she meant that the PTSD wasn't due to the abortion, she could have said PTSD after – when tested after having had an abortion?

A She could have said that.

Q Okay. Doctor, is it correct from this study that 16.3 percent of these young women from 19 on down were dissatisfied with their decision to have an abortion when they were contacted two years later?

A Yes.

Q Okay. Is it correct, also, that 19 percent of this sample said they would not make that kind of a decision again?

A They would not make the same decision again. . . .

Q Okay.

A . . . . yes.

Q And is it also correct that Dr. Major found that over time the negative emotions increased and decision satisfaction decreased?

A That's what it says.

Q Okay. And does she also say that although sadness and regret are not psychological disorders, these feelings should not be dismissed; is that correct?

A Yes.

Q Do you agree with that?

A As long as we understand that that has to be compared with the other possibilities, the other choices these women could have made at the time. We don't know.

Q Dr. Stotland, is it correct that Dr. Major concluded as well that the data in her study did not address truly long-term adjustment to abortion, and suggested that studies at the five- to 10-year postabortion stage would be useful?

A Are you asking me whether she said that?

Q Yeah. Page 783.

A Yes.

Q Okay. And you agree with that?

A Well, the problem is that there's so many intervening things that happen to people over five or 10 years that it becomes really impossible to determine what they're due to, and so I've seen that often in the literature and it's often something that we say about various sequelae, but I don't know that at 10 years we would know how much of a person's state to attribute to an abortion and – and how

much to attribute to the thousands of other things that have happened to them in that interval.

Q So your answer is you don't agree with her.

A Well, she says more women may have experienced intervening events, so – but. . . .

Q She says abortion. . . .

A . . . . I agree that – that the data don't address five through 10 years adjustment – adjustment five or 10 years later. Yes, I agree with that.

Q Doctor, you would agree, would you not, that a woman having had an abortion, especially as an adolescent, might have some emotional trauma at the five-to-10-year range due to the abortion?

A Might?

Q Sure.

A Yes, might.

* * *

Q Okay. Well, Doctor, whether or not the abortion itself is what trips the trigger for a suicide attempt, would you not agree that a minor who's living at home, 16 or younger, that her parents are probably her best defense against a suicide?

A Defense against a suicide. I'm trying to think of – we've had several initiatives about adolescent suicide, but I can't remember anything ever being framed that way, and, in fact, we're working very hard in the American Psychiatric Association and the National Mental Health Association to get parents to be more aware of the possibility

of suicidality in their children, so that would say to me that parents aren't aware as much as they might be, but whether they're better than other possible sources, probably on average.

Q Well, Doctor, if a secret abortion, that is, one that's held from the parent – well, let me withdraw that and ask this. If parents know that their child has had an abortion, are they in a position to monitor that child for both physical and emotional consequences?

A Yes.

Q Okay. If they don't know that she's had an abortion, are they in the same position?

A Well, they could certainly and ought to be monitoring their child's physical and psychological well-being, but they wouldn't know that particular procedure had happened, and to. . . .

Q And isn't it correct that because of your position on this law you don't think it's particularly important that parents do know?

A No, that's not true.

TESTIMONY OF DR. RICHEY

Q And you don't have any concerns that perhaps a girl as young as 11 year [sic] old might not really be able to give an intelligent, informed consent for that procedure. You have no concerns about that.

A I have concerns about everybody being able to give informed consent, to make sure that the consent is informed

before I do anything, regardless of the age of the person and. . . .

Q Well, you would agree, Doctor, that some girls in this age range are not capable of giving informed consent, would you not agree – would you agree to that?

A Yes, and there are some people that are 25 that are not capable of giving informed consent because they don't understand the issues involved.

Q And you agree there are no medical studies showing that 16 and – girls and under can give informed consent, are you?

A Not specifically aware of – of studies directed at that population.

Q And do you think that it's beneficial to have parents involved in getting informed consent from girls of this age?

A Yes.

Q When a parent is present when you're administering prenatal care do you ask the parent about – questions about the child's medical history?

A I try really hard to direct all my questions about the pregnancy to the patient. It's – I consider it to be pretty rude to ha – to talk to the parents about the patient when the patient is the patient. I talk to her, and if the parents interject something that's fine, or if I ask the patient a question and the patient doesn't feel comfortable answering the – or I sense that she doesn't feel comfortable answering the question with the patient – with the

parents there, then I occasionally will ask the parents to step out and I'll talk to the patient by – by herself.

* * *

Q In situations where a minor makes a prenatal choice that endangers her health, Doctor, you always try to involve and get the parents involved in that decision, do you not?

A Yes.

Q In fact, I believe in your deposition you couldn't think of a situation of when you didn't get the parents involved when that type of situation had arose.

A Again, getting the parents involved is – is – I guess that's the way you want to put it. It's a matter of semantics. But the – the parents are involved. The – me specifically going out and involving a parent would happen if the patient was not in – you know, telling the parents what was going on and, for example, the patient wanted to do something that would – that would endanger her life and there were – the parents had been involved, then I would ask her permission to discuss that decision with her parents, yes.

Q And I think you do this because you believe there's some benefit in having parents influencing their daughters to do what's in their. . . .

A Absolutely.

Q . . . . best interest.

A I think parent support of their – a supportive parent is extremely helpful in managing a pregnancy, yes.

Q Do you think we need to have a law which allows parents to force children to have abortions when it's medically necessary?

A No.

Q In fact, in – the situation is that in most all – in most situations when you get parents involved they're going to be able to convince the child to act in their best interest and follow procedures you recommend; hasn't that been your experience?

A In – in some. In – I can – I guess probably most. I don't know the exact number. In some cir – circumstances the parents are urging their – their patients to make a decision that I would consider to be the less optimal decision.

* * *

Q And you agree, Doctor, that good prenatal care is always in the best interest of a child, isn't it?

A Yes, I would agree with that.

Q And you agree that abortion may or may not be in the best interest of a child.

A Yes.

Q If your own 14-year-old daughter was pregnant, would you want to know about that, Doctor?

A Uh-huh.

Q If she was seeking an abortion, would you want to know about that?

A Sure.

Q And you agree, Doctor, that girls in this age range, 16 and under, are more impulsive and make more impulsive decisions than adults; isn't that true?

A No, I don't agree with that at all.

Q Doctor, I bring to your attention transcript, page 47, all right?

UNIDENTIFIED SPEAKER: I don't think she has a copy of it.

MR. DAVIS: Well, don't worry, she'll have it in a minute.

A Is – it's not. . . .

Q Doctor. . . .

A Where are we at?

Q Just one moment, let me find the reference. It's page 49. Doctor, this is the question that was asked you: Do you have an opinion as to whether minors are more likely than adults to engage in impulsive behavior, generally?

Answer: I'd say in general, yes.

A Again, you're talking about impulsive behavior in general as opposed to impulsive behavior specifically. You know, there's impulsive behavior – I've – I mean, in regards to decision making about an abortion. You also specifically asked me about impulsive behavior, do these patients make these incisions – decisions impulsively, and I told you that they are not allowed in my practice to make them impulsively.

Q Well, the question I asked and going back to this way, that minors are – tend to be more impulsive than adults, and you agree with that. . . .

A In a lot. . . .

Q . . . . general. . . .

A . . . . of areas, yes.

Q Okay. And do you think it's important in your 14-year-old daughter when she's pregnant, seeking abortion, that you get involved in selecting the person who is going to do that procedure?

A I'd want to be, yes.

Q And you would want to ensure that she is provided the most experienced doctor and most competent doctor in exercising that procedure; is that. . . .

A That's. . . .

Q . . . . correct?

A . . . . correct.

Q And you recognize, Doctor, there's difference in quality and talent between one doctor from another in performing procedures; is that correct?

A Correct.

Q Now, you are expert in ultrasound, are you not? I mean, that's one of your fields?

A Yes, sir.

Q Now, the other doctor who's well known in this field is Dr. Isada; is that correct?

A Uh-huh.

Q And you know him quite well. And do you. . . .

A Uh-huh.

Q . . . . think he's quite competent?

A Uh-huh.

Q And do you and Dr. Isada agree that when you're performing D & E abortion procedures you should always use ultrasound to make sure that you don't have any components left over after the abortion?

A No.

Q So you don't – you would not agree with Dr. Isada in that position.

A No.

Q Right. You understand that doctors disagree in this area?

A Yes.

Q And you're one of the doctors that is of opinion that it's not necessary, while Dr. Isada believes it's necessary.

A Well, I think it depends on the situation. Again, it – it depends on the gestational age you're discussing, it depends on the particular pregnancy, the uterine complications. It depends on the experience of the person providing the abortion. There are a lot of people that perform D & E's without ultrasound guidance, and traditionally they are performed without ultrasound guidance and they are performed very safely without ultrasound guidance. Other

people that have used ultrasound exclusively – for example, Dr. Isada – don't feel comfortable doing them without an ultrasound, and in his case he should do one with an ultrasound because he doesn't feel comfortable doing them without one. For those providers who are trained to do them without one and feel comfortable doing them without one, then I think they're perfectly capable of doing them without one.

Q So even the top doctors in the field in this area in Alaska, which are you and Dr. Isada, can disagree on what's necessary for – in order to have a safe abortion; isn't that correct?

A I guess that's probably true.

Q So you can understand and you agree that the selection of who the abortion provider is is an important decision as far as the patient is concerned.

A Uh-huh.

Q And, Doctor, your 14-year-old daughter, would you also want to know if she was engaging in unprotected sex?

A Absolutely.

Q And you would want to counsel her about the dangers of STDs and potentials of being pregnant again, right?

A I would already have.

Q Right. And you agree that in dealing with girls of this age they often need to be told more than once; is that correct?

A Absolutely.

Q And, Doctor, if your 14-year-old daughter was being abused by an adult boyfriend, in other words, having sexual relations with an adult boyfriend, you would want to know about that, too, wouldn't you?

A Sure.

Q And you'd want to try to stop that, wouldn't you?

A And I would prosecute him.

* * *

THE COURT: We're back on record. Cross-examination continued.

MR. DAVIS: Thank you, Your Honor.

Q Doctor, you would agree, would you not, that it's in the best interest of a minor to have a caring parent monitoring for postoperative care for abortions?

A A supportive parent, yes.

Q And you agree that minors tend to delay abortion decisions; is that correct?

A Sometimes, yes.

Q And this is from the fact of their inexperience, and also the problems with denial; isn't that correct?

A Sometimes, yes.

Q And you'd agree that the longer the delays, the more likely there will be complications; is that correct? In the abortion.

A That's correct.

Q And the more likely there are going to be complications, the more the need for parental assistance in monitoring those complications; you would agree to that, right?

A The – the need for monitoring increases, yes. Whether it's parental or otherwise is. . . .

Q Regarding this. . . .

A . . . . depends on the parent.

Q Finished?

A Yeah. I just said depends on the parent.

TESTIMONY OF JUDGE MARTIN

Q What is your current position?

A District court judge in Minnesota.

Q Okay.

A Off – office in Duluth, Minnesota.

Q And how long have you been a district court judge?

A Twenty-four years.

Q And what types of cases are you responsible for?

A Well, I've presided over juvenile court throughout that time. I also do probate. I've done a lot of family court.

Q Okay. And prior to becoming a judge how were you employed?

A I was a legal aid attorney for about eight years.

Q And what types of cases were you responsible for as a legal aid attorney?

A All types of civil cases, but it included a huge number of divorce cases, landlord-tenant, bankruptcy, creditor problems, things like that.

Q And what is your educational background?

A Well, I graduated from college and law school.

Q And where did you attend college and law school?

A Oh, I went to Princeton University for college and Yale Law School.

Q Okay. And in your duties as a district court judge do you have occasion to interact with minors seeking abortions?

A Yes, I do.

Q And in what capacity do you interact with these minors?

A Well, I preside over – well, almost all of the judicial bypass proceedings.

* * *

Q Okay, and when the minors tell you either that they've been subject to abuse or they fear abuse, what do you understand abuse to mean?

A Well, I'll ask them – I mean, if they just the word abuse I'll ask them what they mean by that. I'll ask them what's happened and – and it might be physical, it might be emotional abuse, it might – you know, they'll go into

some details about what occurred. They'll – and I'll ask them if they have fear about what might happen, I'll ask them, well, why do you think your parent would – how do you know your parent won't be comforting and offer you some support and advice and maybe they'll be in your corner, and why don't you – why do you feel that it's not worth the risk? I mean, maybe it'll turn out just beautifully and – you know, I'll ask them questions like that. The – then I'll ask them about their plans for the future. . . .

Q Okay.

A . . . . where they are in school, what they intend to do in their future, do they intend to go on to secondary school is what they'll be talking about, or they'll be talking about their employment. Some of them work already some of them have plans for a future career. I'll ask them how the pregnancy might fit in if they carry to term, can't they fulfill some of those goals or whatever. We'll go into the future a little bit to see if they're [sic] considered that as a mature person would do. And that's about – I think that's about the outline of the questioning.

Q Okay, and do the minors often tell you that their future plans are one of the reasons why they want to have an abortion?

A Yes, they've – they almost all want to go to secondary education, whether it be vocational or college. They have careers in mind that they're dreaming of. They – and they – they're convinced in their own mind that there's no way that they could carry to term, have a child and still pursue these – these plans.

TESTIMONY OF DR. WHITEFIELD

Q What is the youngest patient that you've had that has been sexually active?

A The only one that I can remember specifically for me is – is a 12-year-old that I delivered a baby to. I – I remember the situation because it was unusual. I delivered this 12-year-old who had a child, and her mother was with her, who was 24, and her grandmother was with her, who was 37, and it struck of the 13-year, 12-year, 12-year relationship between these two. It was just sort of the numbers that rung in my head. That's one of the reasons I remember that one.

Q And what is the youngest abortion patient that you can recall?

A I personally can't put a number on that. I know that I've looked at our clinic statistics for the clinic as a group, but I can't put a number on that for me.

Q And what about the clinic as a group?

A I believe our statistics show that the youngest person we performed an abortion on was 12.

* * *

Q All right. Now, I'd like to ask you some questions about your experience with parental involvement with your minor patients who come in for care. Do minors typically have a parent accompany them to your office?

A Many minors will come with parents.

Q And do you feel like you can put a percentage on that at all?

A This question was asked in my deposition previously, and I'll give the same answer I gave then because it's the best way I can give. Prior to coming to one of my depositions I asked the members of my group if they could try to put a number on the patients who presented for pregnancy terminations who may have a parental accompaniment, and the number was approximately 50 to 60 percent. I've not really thought about that issue in terms of people who come for nonpregnancy-related events.

Q Okay. And do your minor patients ever come with an adult other than a parent?

A Yes.

Q And what – who have those people been? Can you just give the Court an idea?

A A broad spectrum of people. It could be a grandmother. It could be an aunt. It could be their friend. It could be a supportive friend. It's almost impossible to tell.

Q Okay. And do you routinely talk to your patients that don't come with a parent about why the parent hasn't come?

A I don't necessarily ask why the parent hasn't come. I assume that the person who's come has made a decision to involve them or not, and that's the patient's choice.

* * *

Q Okay. And I'd like to focus now on the first trimester surgical abortions. Is it fair to say that that is the majority of abortions that are performed at Alaska Women's Health Services?

A Yes.

Q Now, how many days does it take for that procedure?

A It can be done either as a one-day procedure or a two-day procedure.

Q Okay, can you tell the Court when you would do it as a one-day procedure and when you would do it normally as a two-day procedure?

A The – the key to successfully completing a procedure with minimal complications is trying to ensure that the cervix is dilated as atraumatically or as easily as possible. In a person who's had several children vaginally it's pretty easy to dilate the cervix. In a person who is very early in pregnancy the cervix doesn't have to be dilated very much. So we try to isolate one-day procedures predominantly to the people who are early in pregnancy, who have had a number of vaginal births. That minimizes the trauma to the cervix. In people who are either further along in the first trimester or have not had any vaginal births, then we would try to do that as a two-day procedure and use passive cervical dilation with Laminaria to more atraumatically dilate the cervix from the first to the second day.

Q And what is Laminaria and how does that work?

A Laminaria is a – literally a piece of seaweed. It comes from the plant name Laminaria japuncum (ph), and the Japanese are the people who perfected this technique, and this piece of seaweed is taken and sterilized and dried, and then the day prior to the pregnancy termination the Laminaria is put inside the patient's cervix. Now, much like a sponge which is dry which absorbs moisture and expands, the Laminaria can absorb moisture from the

cervical os of a patient, and over a time period slowly expand, and it's felt that a slow dilation of the cervix is more atraumatic than a rapid dilation of the cervix.

Q Based on what you've said, Doctor, is it fair to conclude that most of your minor patients you would want to do a two-day procedure on?

A Yes.

Q All right. Now, I'd like to focus. . . .

A The rea – the reason I say that – that's true, and the reason I say it is because most of the minor patients haven't had a vaginal birth, but if I had a minor patient that had several children, then that person may be an exception.

A – I saw a woman last week who was 19 who was having her sixth child. That would be a person whose cervix would be easy to dilate.

Q Okay. I'd like to now go through the process that a patient would go through when they come to your facility for an abortion. First of all, is there a difference between the process for minors compared to adult women?

A No.

* * *

Q Are there any medical conditions that you've encountered that have prevented you from doing an abortion?

A Absolutely prevented me? No. By and large, if a person has a medical condition that would make abortion a significant risk, it will clearly make pregnancy a risk, too. I mean, carrying a pregnancy to term is by and large

going to be more of a problem for the patient than the pregnancy termination.

Q All right. Now, after you obtain a medical history from a woman who's coming in for a termination what would be the next step for her in the process?

A After a history is obtained then the – there's two steps which can occur almost interchangeably. One step is that all patients who – and we're speaking now of first-trimester abortions in my office.

Q Yes.

A The person may get an ultra – well, will, not may – will get an ultrasound done to confirm where in pregnancy they are. That's to ensure that a person's either further along than we think they are or earlier than we think they are, or that they have an ectopic, which would be a whole different issue. That's one step, ultrasound. Second step would be looking at a general short video that we have regarding a pregnancy termination and what to expect and what sort of the issues are around pregnancy termination. Those two steps can be done sort of in any order.

Q Okay. Let me ask you about the video first, then. What – what's on the video?

A It's a – it's a general video. It's – it's meant just to give people a little bit of information about what to expect from a first-trimester pregnancy termination, what's going to happen to them in the office, how the procedure will go.

Q Is abortion the only procedure that you use a video like that for?

A No. That's a commercially-produced video, and we may have many videos. We have them for hysterectomies, colposcopies, tubal ligations, laparoscopies. They're available for all kinds of procedures.

Q And do you have a video for second-trimester abortions?

A No, we don't.

Q Why is that?

A I do virtually all of that counseling one on one myself.

* * *

Q Okay. Now, I'd like to have you go on to what's been – the number 53, Bates stamped 53 at the bottom, and what is this form?

A This form specifically talks about the Laminaria. It's a separate form for two reasons. First of all, not all patients get Laminaria, so in some cases it would be inappropriate. And the second case really is to try to emphasize to the patient two real important things. One is that the introduction of the Laminaria introduces a potential pathway of an infection to go from the vagina to the uterus, and so with the introduction of that Laminaria it increases their risk of developing an infection later on. Should the patient choose to change their mind and not have a pregnancy termination, it increases their risk of carrying their pregnancy because of this placement of the Laminaria which is a rather unnatural thing.

The second thing from a functional point of view is a reemphasis that knowledge of how many Laminaria and that they are there is important, because if the person

comes back the next day for a pregnancy termination and overnight they have lost the Laminaria, we're as providers the next day given this question to deal with of did the patient pass all the Laminaria or could have any gone inside the uterus. So we really try to encourage the patients to be aware of the Laminaria, if they think anything has come out of their vagina, to pick it up and bring it into the office so we can examine it.

* * *

Q Okay. And what's the – what are the next sheets after that?

A This is information which is presented to the patient, but also is written information that – for them to take home, which has to do with things that they should watch for after a pregnancy termination is done that may be a sign of a problem, and then gives them the vehicle or avenue to contact us if they have concerns.

Q Okay. Now, after the patient has had a chance to look at this information does she have an opportunity to ask questions?

A Yes. Uh-huh.

Q And who does she – who would she be usually doing that with?

A Usually it, again, would be the – the nurse midwife, although sometimes patients will ask me these questions, like if I'm going to do a pregnancy termination and somebody – somebody asked me to go back over everything again, I've been through this but I want to hear it from you, Dr. Whitefield, and I want to ask you questions about concerns or complications.

Q And if the nurse midwife or nurse practitioner has any questions about informed consent, then what happens?

A They come to us as the providers.

* * *

Q Okay. Now, in a typical two-day procedure when do you see the patient?

A Typically I would see them on the second day.

Q Okay, and that would be before or after the informed consent has been done?

A That would be after.

Q Okay. Now, do you have – what conversations do you have, then, with the patient when you meet with them?

A Usually I walk in and, first of all, try to make the patient more comfortable, because nobody wants to be in that room. None of the patients want to be there. So I'll talk with them to try to make them more comfortable, and then I usually ask them if they understand what's going to happen, what the procedure's about, if they have – if they understand what to expect, and if they have questions about the procedure.

Q Okay. And in your office procedures do you use general anesthesia?

A No.

Q And how long does the procedure itself usually last?

A Usually approximately five to seven minutes.

Q Okay. Now, as part of – and then after the procedure how long does the patient usually stay at the facility?

A It – it depends on whether or not they've had IV sedation and how they're recovering. The short end would be a half-hour. The long end would be two hours.

* * *

Q Now, in your practice the State will pay for a minor girl's abortion – and again we're – I'm speaking now at this time of – when I speak of a minor I'm talking about the classification of 16 and under for our purposes of definitions – and the State will pay for any abortion that is medically necessary; is that correct?

A Correct.

Q And since you've been practicing since 1985 you have been able to find a medical necessity for State-paid abortions for these girls except perhaps for only 10; is that correct?

A I believe that's what I said in my deposition.

Q And your definition of medical necessity is what you refer to if the pregnancy is an affront to the minor; is that correct?

A It's that the pregnancy in some way is a threat to the patient's medical or psychological well-being.

Q And what you use for a definition is a theoretical hazard to her mental health; is that correct?

A I think I've used those terms.

Q And this could mean that if, in fact, the pregnancy would cause her some conc – problems in dealing with education, her continued employment, things of this nature, would be the kind of affront you're talking about; is that correct?

A Independence would be another one, the ability to raise a family. There's multiple factors that will go into it.

Q And you indicate you've been performing abortions in this state since 1985; is that correct?

A Correct.

Q And you testified it's come to your attention during this – these years of practice that some of these girls were impregnated by adult boyfriends; is that correct?

A That's correct.

Q The truth is you have absolutely no records showing that you have ever reported to the State of Alaska or turned in any boyfriend for sexually abusing a minor girl; isn't that true?

A Can you restate the question, please?

Q You have no records or written proof that you have ever filed any report with the State of Alaska turning a girl – adult boyfriend in for having sexual relations with a girl 16 and under; isn't that true?

A That is – that is correct.

Q You have never filled out a police report setting forth statements indicating to you that you discovered that

a girl 16 and under was sexually abused by an adult male; that is true.

A Restate the question, please.

Q You've never filled out a police report reporting this, have you?

A Oh, that's – that's a – that's a different question. You – the first thing you asked me is whether I had the records, right.

Q The record. Now, have you got a police report?

A I – I know that I have interviewed with – with policemen. Now whether – whether I've actually filled a report out, I can't tell you.

Q You don't recall ever writing out a written statement.

A I don't recall writing out a. . . .

Q Something in writing, so we can find out if it's actually been done.

A I don't. . . .

Q Something in writing.

A . . . . recall writing out a statement.

Q So you're not – you don't remember any written statement, do you?

A That's correct.

Q And you've never been subpoenaed to testify before a grand jury about you discovering this statutory rape, have you?

A I have not.

Q You've never testified at trial about reporting any statutory rapes that you've discovered; is that correct?

A I have not.

Q And isn't it true, Doctor, that when a girl 16 and under comes to your clinic you don't ask her the age of the father who impregnated her, do you?

A We do not.

Q In fact, if she's brought to the clinic by an adult male, you don't even bother to ask her what the relationship she has with that adult male, do you?

A No.

Q And this is consistent with your policy, isn't it, Doctor, of your clinic of don't ask, don't tell. Isn't that your policy?

A Our policy is if we become aware of a situation where a minor may have been impregnated by an adult male that that's a reportable event, and we would certainly turn that in.

* * *

Q Now, you've indicated in your prior testimony, Doctor, that you don't consider age a problem in getting informed consent; is that correct?

A I think that getting informed consent is an interaction between the provider and the – and the patient, so I have to sit down, talk to a patient and get a sense for whether what I'm saying to them makes sense, whether they can understand it, whether they can parrot things

back to me, and in the process of doing that make a decision as to whether I think they understand what's going on.

Q All right, back to my original question. Haven't you previously stated you don't consider age as a problem in getting informed consent?

A I personally haven't had that be a problem for me in my contact with patients.

Q In fact, Doctor, you have never denied an abortion to a girl who's come to your clinic without a parent due to an inability to give informed consent; isn't that true?

A I have. . . .

Q I'm talking about a child that's come without a parent.

A Uh-huh. A person who's 16 or – or younger.

Q Or younger.

A Uh-huh. Not the best of my knowledge.

Q In fact, you've never denied an abortion to a girl 16 and under who came to your clinic without a parent due to the fact of her immaturity; isn't that true? I'm talking about just general immaturity, you think this girl's too young to make an abortion decision. You've never denied an abortion to a girl based on that finding that's 16 and under who came to your clinic without a parent.

Q I don't think immaturity is a term that we've talked about here at all.

Q Well, would you recognize the possibility that a girl who came into your clinic, say 11 years old, just might

not be able to be mature enough to make a rational intelligent decision regarding whether or not to have an abortion? Could you possibly recognize that as a possibility?

A It's possible.

Q But you have never experienced that in the entire history of your practice where you found a girl who came in, at least we know as young as 12, anyway, that you thought was too immature to make such a decision without parental assistance; isn't that true?

A In my experience of one or two 12-year-olds, no, that's true.

Q Thirteen-year-old as well, right? Fourteen-year-olds as well. Never have had one. That's what we're saying, right?

* * *

Q Don't you on your previous testimony say I don't go and sit and watch these nurses go over these – explain these medical terms?

A I did, but that doesn't contradict my testimony right now.

Q And you also said I have no idea whether or not they understand the terms or not.

A When I sit down and talk with them, then I get a sense for whether they understand the terms or not. I think you might also re – remember when I gave my statement I said if I talk to somebody about dismemberment, that the reaction that they have in front of me gives you clues as to whether they understand what you're saying or not.

Q Well, the truth of the matter is, Doctor, that you don't talk – sit down and talk with every one of them. You only sit down and talk with one if something comes up or someone asks a question. As a matter of course, if a little girl comes in, she gets the infor – the doc – the nurse practitioner gets her informed consent, gets her medical history, she comes in and she doesn't ask any questions of you at all, and you kind of say you got any questions and the little girl says no, after that that's about all you ask, isn't it?

A No. Not necessarily. I may sit down and say do you understand what's going to happen, this is what I'm going to do, this is the order in which I'm going to do it, this is the sequence of things, this is what you're going to experience.

Q You said "may." That doesn't mean you always do it, does it, Doctor?

A I would say I do it in the majority of cases.

Q All right. And how – and then this is – how many minutes does this all take? When you sit down and go over the final checklist.

A Can't tell you.

Q Uh-huh. Just a few minutes, isn't it, Doctor?

A Probably.

Q And one – and the informed consent form – let's go to the warnings about – guess it's in batch number 0053, the Laminaria. Is that pronouncing that – Laminaria warning.

A Yes, sir.

Q All right. And in most of these cases these girls are going to have Laminaria; is that correct?

A That's correct.

Q And they're going to be responsible to go home on their own with the Laminaria; is that correct?

A That's correct.

Q Those who don't have their parents are going to go home alone with the Laminaria; is that correct?

A That's correct.

Q And what you tell them is they get – find out whether or not they understand it, is based upon this informed consent they have to sign; is that correct?

A Please restate the question.

Q Well, this is the informed consent that the 12- and 15-year-olds are going to have sign just like the adult women; is that right?

A That's correct.

Q And what you tell them there in this informed consent, you must remember that the Laminaria is part of the abortion procedure, and it's very important that you return to the clinic the next day. Once the Laminaria is inserted you are at great risk for infection and complications that could result in sterility, loss of the uterus, ovaries, or death.

A That's correct.

Q Right. What's going to happen if this 12- or 13-year-old girl doesn't come back the next day, Doctor?

A We go to exceedingly great lengths to find them.

Q Right. And if they're living with their parents and for some reason the parents decide it's time to go on a holiday and they can't come in, what are you going to do, Doctor?

A We will utilize all information that's available in our chart to locate the patient.

Q And that girl could die if you can't find her; isn't that true?

A It could happen. It has never.

* * *

Q Well, the bottom line is you don't have to have any specialized training in order to perform abortions, that you just need an M.D. degree; isn't that true?

A I believe that that's true.

Q And, in fact, you don't even have to be a doctor to be running one of these clinics. Any private citizen could start an abortion clinic up and have some doctors hired to perform abortions; isn't that true?

A That's true.

Q So you're sort of the poster child for providing abortions. That's really what we're talking about, aren't you, Doctor?

A I would be flattered to take that compliment, but when I compare myself to the – the other people who practice abortion in this state, I think that we have exceedingly competent abortion providers in this state.

Q All right. But you consider yourself one of the top providers in the kind of care that you provide your patients; isn't that true?

A I consider that we try very hard to do a good service.

Q It's your position, though, isn't it, Doctor, that when these girls we're talking about, these 16 and under girls, they are held responsible for their postoperative care just as if they were an adult; isn't that true?

A Yes.

Q They're treated the same.

A Yes.

Q And you've indicated, also, that minors tend to get later abortions than adults; isn't that true?

A Yes.

Q And you agree that minors who get later abortions have – likely have more – greater risk for abortion complications; isn't that true?

A Yes.

* * *

Q Dr. Whitefield, you were asked about the possibility that a patient following an abortion could die within 24 hours of an infection. Do you recall those questions?

A I do.

Q And what do you think that poss – do you think that's possible?

A If it's possible, it is exceedingly remote. Exceedingly remote. I have never seen it. It's possible – I – I don't know that I've ever read about it. It's not on my radar screen.

Q Do you take any precautions against infection for your patients when they leave the clinic?

A Everybody who has a pregnancy termination with us gets antibiotics in the perioperative period, so just before and just after the procedure.

Q And why do you do that?

A To help prevent infections.

TESTIMONY OF MR. COOKE

Q Okay. You would agree, would you not, that a parent's assistance can often be beneficial to a minor faced with an unwanted pregnancy.

A I – I would hope that a minor's – the parent could be ben – parent's assistance to a minor would be beneficial on hundreds or thousands of things, including this one.

Q Including an unintended pregnancy, correct?

A Isn't that – yeah, I think that's what I just said.

Q Okay. And, sir, is it correct you also believe that it's a bad idea, probably, for a 12-year-old girl to decide to have an abortion with only the advice of a doctor who's going to provide the abortion?

A I – I'm not sure if I accept that statement. I mean, I think it's a bad idea for a 12-year-old to be pregnant or to have a child.

Q Okay. Do you remember making that statement in your deposition, sir?

A I – I could have. I know you asked me such questions along that line.

Q Okay. And – well, would you like to look at. . . .

A I'm not denying it. I mean, yeah, there's lots of things about a 12-year-old being pregnant that, you know, I view as not good – not good circumstances, if that's – I mean, if that's – if I'm to – if the purpose of this discussion is to talk about, you know, that kind of a value judgment.

Q And your time on the bench in Bethel ended in 1986; is that correct?

A That's right.

TESTIMONY OF DR. TSAO-WU

Q Let's talk about medical histories and the information you gather regarding your adolescent patients. In your treatment of adolescents is it sometimes necessary to gather medical histories, personal and family medical histories from your patients, and information about their past medical treatment?

A Yeah, it's – it – yes, it's almost always necessary to gather information from a patient of any age, and, of course, when they're very young you're limited in your ability to do that, and so with – with any of my patients,

again, zero to 18, I rely heavily on – on what the parents' input is. So for obtaining medical history, whether it's how long has this cough been going on to, you know, chronic disease management, I rely heavily on parents' input.

Q We'll talk about that, the parents' involvement in a second, but for now can you give me examples of when and how gathering a medical history, personal or family, on an adolescent patient might be critical to their health care?

A Well, our approach in – in medicine is to understand the data and synthesize a diagnosis and then come up with a treatment plan, so if you don't have that data it's very difficult to – to come up with a treatment plan. So, more specifically, if I'm asking an adolescent about their cough and they don't remember how long it's been or what initiated it or, you know, many other things about it, then I won't be able to really provide them with a good diagnosis or reasonable diagnosis, I'd guess, and then my treatment might also be haphazard in, you know, to some degree because of the limitation on what kind of quality data I can obtain. And then, of course, even if I do guess right, then – then there's compliance issues, and so, you know, if I'm treating somebody then based on scientific research on what works and what doesn't, then my hope is that that patient is going to stick with my treatment plan, and so all those aspects of – from – from initially seeing the patient and understanding their – their disease process to treating them and following up on them are I think better done with a parent involved, and to be able to help with providing data and helping the patient themself understand the disease process, and helping with compliance and follow-up.

Q Thank you. Does the medical history you gather on a patient differ depending upon what particular procedure or treatment you might be providing?

A Not substantially. There can be different emphases, but basically when a physician encounters a patient, whether it's in a clinic or emergency room or admitting them to the hospital or for surgery, there are basic elements to the history that we are trained to go through, and in understanding the current illness and understanding their past medical history and – and that can heavily impact the decision-making process and the treatment, so there's many aspects to the past medical history that we – that we have to go into.

Q Would it make a difference whether the procedure's a surgical procedure?

A Not substantially. I mean, you know, you absolutely must ask a patient what their drug allergies are whether you're going to trim off one of their toenails or, you know, treat their ear infection. So you obtain all this history, and, of course, sometimes you do that at a prior visit, and so you don't have to go through the whole thing every time necessarily, but there – there are aspects of the medical history that seem perhaps unrelated but can shed some light on the disease process, as well as prevent complications. For instance, giving the wrong antibiotic for somebody's toe infection and – or giving an antibiotic that the patient didn't realize they were allergic to can be disastrous.

Q Do you ever have occasion where a patient comes to you from another doctor and you might need to get a medical file, a past medical file from another doctor?

A Yes, often.

Q If that adolescent patient comes to you without a parent, do you have the ability to get that other medical file without parental consent?

A Only certain aspects of the chart under emergency-type situations. Otherwise, people are very – people know to not give their patients' information out even to doctor's offices without the parents' consent.

Q So the typical method of even obtaining a prior medical file from another doctor is parental involvement; is that correct?

A Yeah.

Q Is it in your opinion is it important to involve parents in the process of obtaining these medical histories from adolescent patients, and if so, why?

A Yes, I think it's very important, and that's because of a number of reasons, but in my experience there's a wide range of – of responsibility and understanding of – of a person's past medical history, and so – and even the current illness, and so when I'm – when I'm trying to talk to a – an adolescent I may have a conversation that sounds pretty normal to anyone else, an adult, or I may have a conversation where I only get some yeses and no's and – and I don't knows, and shrugs of shoulder, and that's about as far as a patient can – can get, can muster. So – and, again, you know, I'm in the habit of – of using both sources for information for my medical care. I look at the patient, I ask them how they're doing, whether they're four or 14, ask them what's wrong. I look at the parent, too, and I say, you know, is that – is that the story and what else can you

tell me. So I need to – I need that – I need data from both people.

Q Do you ever rely exclusively upon an adolescent patient to provide you a medical history, family or personal?

A Sure. If they are – if – if there are certain situations where I don't – where the condition doesn't pose itself as a threat to the – the patient's health and there's no way for me to get in contact with the parent, or if I'm restricted by law to not consult the parent, then I might proceed anyway. If I've seen the patient before, for example, for the same problem and they're here for another treatment of the same issue, then there's – you know, from a practical standpoint it's easy to proceed with – with treatment.

Q Doctor, what has been your experience and observation regarding the ability of adolescent patients to communicate with their physician regarding their medical care?

A Well, I think I mentioned that the conversation can be one – can range from fairly coherent and – very coherent and comprehensive to grunts and shrugs of shoulder and, you know – I mean, maybe – maybe it's just me, but I think there's something that happens during the teenage years that sometimes causes people to have trouble communicating.

Q Is your experience with adolescent girls age, say 11 to 16, any different in this regard?

A No.

Q And what has been your experience and observation regarding adolescent thinking and decision making with respect to their medical care?

A That – well, with – with any patient there's this gap between what they understand is the problem – you know, they may just feel pain – and what we're trying to convey as – as the condition or diagnosis or – or the problem, and so, you know, we're always trying to bridge that gap of – of lack of understanding, and that's a challenging thing to do in – in teenagers, I would say.

Q Focusing specifically on adolescents, teenagers, say 11 to 16. . . .

A Uh-huh.

Q . . . . what is the nature of that gap, as you called it, in terms of trying to convey information and obtain information?

A A lack of understanding of pathophysiology, a lack of understanding of anatomy, lack of understanding of even reality when we have to deal with a problem and the patient doesn't want to, then it's pretty easy to deny that there's a problem or not want to face it or ignore it, so that's part of the gap that needs to be – that we're trying to talk to the patient about.

Q In your experience and observation how typical has that been, denial, in the context of your interaction with adolescents [sic] patients and their medical care?

A It depends on the severity of the condition. A person with a sore throat is – is not going to deny that they might have strep throat, but somebody who might have to undergo a surgical procedure might leave the room

upset and never come back, so it's – it – there's a wide range again there, depending on – I don't know if that answers your question or not.

Q Sure. What's been your experience with adolescent patients and their ability to follow your medical instructions for their care?

A That's a constant source of – of struggle for me as well, because, you know, for example, with – asthma care patients do better if they're on preventive medications, and so I often see patients who are noncompliant to a certain degree, so I will assume that they are noncompliant and ask them how much they've been able to take their medication, how many days out of 30, and so it's the rare adolescent who – who, you know, keeps up with their medication and says 30 days out of 30, and it's much more common to say – to find that the patient has either stopped the medication themselves or is taking it 15 to 20 days out of 30. So – and, you know, part of the reason we're here is to keep encouraging patients to – to – to take care of themselves, and, again, all of this is made easier by having a parent. Whether the parent is prodding them or gently reminding them or encouraging them, you know, the parent is – is crucial in my practice to – to the management of these kids' disease process.

Q Do you have an opinion, Doctor, regarding what the quality of medical care would be to an adolescent if the adolescent were the only person that the physician were communicating with regarding the medical care?

A That again depends on the condition, so if – you know, if someone comes in with a wart, you know, I can give them the – the car [sic] that they need and meet their expectations, too, so if we define quality of care as being,

you know, the two – the two parties understanding what the problem is and – and dealing with the problem, then there's a good alignment there and lots of overlap. If we're talking about something more difficult, there may be lack of understanding, there may not be appreciation on either part, mine or the patient's about the risks involved and – with their particular situation, and what their compliance might be, you know, sometimes a patient will say, yes, yes, I will take this medicine and may never get the prescription filled. So if the patient is – is by themself, you know, they're at a disadvantage because they are much less likely, I think, to – to follow through on – on treatment and be able to watch for complications and come for follow-up.

Q Now, in your practice have you had occasion where you have interacted with or treated adolescents without their parents?

A Yes.

Q And what's your opinion regarding the quality of the medical care you provided in those circumstances?

A Again, it depends on the situation and what the – the problem was, but, you know, in anything but the least serious interactions it can always be improved if the parent is there and involved.

Q And you talked about interacting with adolescents regarding high-risk behaviors?

A Uh-huh.

* * *

Q This reluctance to communicate with you or with parents about – oh, let's focus on parents – to communicate with parents about the adolescent's involvement in

sexual activity, has that been true in the patients that you have who have good relations – good relationships with their parents?

A Yes, both those who have a good relationship with their parents and those who – who don't enjoy that type of family. You know, they – there's – there's always tension and conflict when the expectations of the parent, and even the patient him or herself are – are not met.

Q So disappointing a parent's expectations, embarrassment about personal matters, those are some of the major reasons why adolescents are reluctant to communicate about these issues with their parents. . . .

A Right.

Q . . . . in your observation? Doctor, in your practice do you obtain informed consent regarding your treatment of adolescent patients?

A When there's a procedure to be done we go through the process of obtaining informed consent, yes.

Q And what is your understanding of what it means for a patient to give informed consent to a medical procedure or to treatment?

A Well, with our patients, because they're underage they – the informed consent comes from the parent, so it's kind of a complex scenario, but just as I've been talking about, in all aspects of medical care with a teenager you are talking both to the teenager and parent about the procedure that needs to be done and the risks involved and the possible complications what I expect them to do in follow-up, and then with – you know, with certain procedures we are basically obtaining verbal consent or – you

know, from both parties, the parent and the teen. And – but when it comes to legal – legally protecting ourselves and to prove that we obtained informed consent, we'll have the parent sign a consent form.

Q Do you feel parental involvement is important in the informed consent process for adolescents?

A I do – I do view it as being very important.

Q Why?

A Again, because the – I think the understanding that a parent can have regarding the importance – or the – the magnitude of the – the problem and the procedure, the problems that could ensue, their understanding lends understanding to the – the patient themself.

Q Do you have an opinion regarding the ability of an average adolescent to give informed consent to a medical procedure?

A Again, it depends on what you would consider informed, I suppose, because a person can consent to something and not truly understand, but – you know, I – I think you can go through the motions of obtaining informed consent with anyone, and there's always gradations of how informed they are and how much they're able to understand. So with adolescents are they better informed with their parents' input and discussion or – yes, I – I believe that is the case. So is the informed consent of – of – sort of less quality when they're alone? I would say that that is the case.

Q Now, you told us in your practice you've had patients, adolescent girls age 11 to 16 who have tested positively for pregnancy?

A Yes.

Q And in your report in this case you describe adolescent pregnancy as being a crisis in a young girl's life. Can you explain what you mean by that?

A Well, in most cases a – an unwed teenager is not expecting that they'll get pregnant. They may be do something to prevent that or they may be doing at all [sic] to prevent that, but for most it's a shock to under – to – to – to find out, and then they must come to grips with something that has a lot of ramifications for both their physical being, as well as every other aspect of them. So it's – it's a crisis in the sense that their usual social situation and their – even their bodily function is suddenly altered, and they then have to face these – these decisions and issues related to medical care and – and interacting with their – their family.

* * *

Q Dr. Tsao-Wu, Ms. Novak asked you about your patients and how they comply with your instructions, and you mentioned that – I think I heard you say that their compliance improves with age. Can you explain why that is?

A Well, I think after a person gets to be – I was speaking gen – in general age up to their early 20s or mid 20s, then they begin to become more responsible for their own health, but I personally don't often find a whole lot of difference between 17/18-year-olds and 15/16-year-olds.

Q Do you believe that it's necessary to have a law mandating parental involvement for a young girl to receive prenatal care, childbirth, medical care? Is it necessary. . . .

A No.

Q . . . . to have a law that requires, mandates, parental involvement?

A No, I think that we can encourage prenatal care, I don't think anybody objects to prenatal care as being something controversial or negative.

TESTIMONY OF DR. JOSEPHSON

Q And can you explain to the Court what Dr. Todd's study was that she did in trying to compare the – these differences occurring in the adolescent brain with actual adolescent behavior?

A Well, what she did actually was controlled – or compared a set of adults, 15 adults, and a set of 15 adolescents, did MRI studies, functional MRI studies, in other words, looked at them while several stimuli were presented to the study's subjects, and these stimuli consisted of pictures of individuals showing various emotions, and – and then they were asked the – the study participants to common [sic] what the emotions were, and they looked at which areas of the brain were functioning during that – that time.

Q And did she find that there were difference [sic] in the way the adolescents process and perceive information?

A Yes. She was – found that the area of their brain, the amygdala, which is part of the limbic system, which is the emotional circuitry, if you will, of the brain was different than – in adolescence when compared to adults.

Q And in her article did she make a conclusion as to the comments on the results of her study?

A She concluded, actually, also commented on the frontal area of the brain, but the frontal area was less active and the amygdala was more active in adolescence.

Q All right. And on the second page of the study can you inform the Court what her final conclusion was?

A She. . . .

Q You may read it if you want.

A She – her quote – she stated this examination, this test makes one wonder how well an adolescent can plan appropriate responses when they're often unable to correctly interpret their environment.

Q All right.

A She based that on the teenagers misreading facial cues more consistently than adults did.

* * *

DR. GIEDD: The putting down phase is perhaps even more interesting, because the hypothesis for that is the use-it-or-lose-it principle. Those cells and connections that are used will survive and flourish. Those cells and connections that are not used will wither and die, so if the teen is doing music or sports or academics, those are the cells and connections that will be hard wired. If they're lying on the couch or playing video games or – or MTV, those are the cells and connections that are going to survive.

NARRATOR: It is not only what a teenager does that matters, but how old he is and what the immature

brain is capable of doing. Some areas coordinate and oversee others, and it is those parts of the brain that have long interested neuroscientists.

DR. NELSON: We've known for a long time that what we actually call the prefrontal cortex, the part that sits behind your forehead, is involved in planning behavior, your use of strategies, a technical term we call cognitive flexibility, which is can you change your mind and do you have sort of a fluid way of going about solving problems.

DR. GIEDD: Part of the brain that is the so-called CEO or the executive of the brain is still being built during the teenage years. Teens are capable of enormous intellectual and – and artistic accomplishments, but that basic part of the brain that gives us strategies and organizing and perhaps warns us of potential consequences isn't fully on board yet.

* * *

DR. GIEDD: The cerebellum in the back of the brain is the part of the brain that changes most during the teen years. So this part of the brain has not finished growing well into the early 20s, even. The cerebellum used to be thought to be involved in the coordination of our muscles, but we now know it's also involved in coordination of our thinking processes, just like one can be physically clumsy, one can be kind of mentally clumsy, and this ability to smooth out all the different intellectual processes, to navigate the complicated social life of the teen and to get through these things smoothly and gracefully instead of lurching through adolescence seems to be a function of the cerebellum. As a society we're less active than we ever have been in the history of humanity. We're

good with our thumbs and our – and video games and such, but as far as actual physical activity, running, jumping, playing, children are doing less and less of that. Recess and play seem to be the first thing that is cut out of school curriculums in – in – in tight times, but those actually may be as important or maybe even more important than some of the academic subjects that the children are doing.

(End of videotape)

THE COURT: Let's turn the lights back on.

MR. DAVIS: May I proceed, Your Honor?

THE COURT: Yes.

DIRECT EXAMINATION CONTINUED

BY MR. DAVIS:

Q Dr. Thompson, regarding the information set forth by the scientists in this videotape, that information do you agree with?

A Yes.

Q And regarding this impairment process that the scientists discuss going on in the adolescent brain, in your opinion does this impairment affect a minor's abortion decision making?

A I – I would – excuse me – re – restate the word impairment. Impairment we use in medicine is – is – is a deficit. This is something that's – it hasn't fully developed. It's just not – not there yet. It – it's a deficit when compared to adult functioning, but clearly that lack of development of that, or impairment as you say, would be very

much related to any important life decision, and certainly one regarding abortion.

Q Doctor, in your expert report we go to – in section B you use the phrase psychosocial development and adolescent pregnancy, and you go on to comment that girls who are 16 and under who are sexually active and become pregnant you define as developmental failures.

A Yes.

Q Could you explain to the Court what you mean by that?

A In simplest terms, when a girl 15, 16, 13 – excuse me – becomes pregnant, it's a clear indication of a problem. This is not a random event and it's not something that we would see is occurring in the process of normal development in – as health, as part of normal healthy development, and so something is missing. The – the things that typically occur when children develop, developing a sense of trust, reliance on others, a feeling of self-confidence, self-efficacy, control of impulses, and developing age appropriate and friendship. These – these typical building blocks are often missing or askew in a child who becomes pregnant, so when there is a child who becomes pregnant it's a clear indication of a problem in almost all instances.

Q This developmental failure, do you believe is something that parents need to address, to correct?

A Absolutely. In fact, I would even go further. Not only need to address, the parents are inextricably involved with the developmental failure. It's not just on the shoulders of the child. If a child is missing something it's a responsibility for a parent to say how did this happen, how

have they missed this thing that most adolescents don't miss, what part do I play. So clearly parents are involved with any developmental failure in its cause, and probably its resolution.

Q In your opinion do adolescents volunteer for appropriate behavior?

A When you say volunteer for appropriate behavior, I'm assuming you mean things that occur in the process of devel – normal development or – adolescents, like – like many of us, but certainly don't volunteer for things that they're supposed to do, if – if that's what you're referring to.

Q Right.

A Uh-huh. Many times they'll resist something that's obviously healthy for them, but they decide not to, whether coming in on time or going to bed on time or brushing their teeth, even, for example, for a younger child.

Q And is that part of parental responsibilities, to sometimes enforce things which minors do not wish to do in order to help them development [sic]?

A Absolutely. I – I would even go further with that of not only the responsibility, but a test of effective parenting is how they deal with the resistances of their children and their difficult moments. It's easy to be a parent when things are going well, but when there are resistances in a child, to work through them is usually an indication of effective parenting.

Q Does a secret abortion hide from the parent this developmental failure?

A A secret abortion hides and delays the inevitable, because parents eventually find out, and it delays the – the inevitable need to deal with the facts, how this came about, and try to deal with this problem, and to keep parents outside of that problem-solving sequence makes no sense at all from a clinical standpoint.

* * *

Q So is it your opinion that a secret abortion is counterproductive for this process?

A It would pre – it'd prevent dealing with the issue, yes.

Q In your report, section D, you go to the topic of adolescent myths as barriers to growth. . . .

A Yeah.

Q . . . . and this section, Doctor, you refer to about – comment about stress is associated with – stress associated with parental involvement is beneficial. Could you explain to the Court what you mean by this?

A Well, as a general rule many of the things that occur in development that are most helpful are somewhat stressful, and the tendency to avoid them is there and real, but to work through that, deal with the stress and master a difficult event, is a crucial aspect of adolescent development. I've used the example of an examination, but to use that again, most young people might enjoy the fact that an algebra test is cancelled because it's overwhelming to them, but they know they need to master it to pass their – their math course. There's a tendency to – to want to avoid things that are stressful, that are good for you, and that difficult moments in a family, avoiding dealing with a

conflict, and, obviously, presenting an adolescent pregnancy is a serious conflict, adolescents would rather avoid that, but the stress of working that through is not necessarily unhealthy at all. In fact, I would suggest it's very healthy to meet it head on.

Q You comment, Doctor, something about the desire of adolescents to both be controlled and have freedom. Can you explain what you mean by that process?

A It's a fundamental part of adolescent development of – to use the phrase – wanting it both ways. Kids want to be treated like they're adults and have their own desires, but at the same time will just turn around and ask for guidance, either directly through their verbal requests or through their behavior, and it's an awkward time of I want to be taken care of and I want to be left alone, and kids typically have several years of this behavior, most – most typically during the years of 12, 13 and 14.

Q Regarding your comments in your expert report in the area of assessing risk factors for negative postabortion adjustment, you indicate that age is a risk factor. Can you explain that to Your Honor – your – Doctor?

A Well, the younger a child the less equipped they are cognitively to understand the consequences of their behavior, the technical aspects of a proposed abortion, the technical aspects of adoption, for that matter. There is just less cognitive maturity and development. In addition, their emotions, as we've already discussed, are more labile or potentially more out of control. Their anxiety, which we all face when we're asked to deal with a situation that's very difficult, is much more so for a child, and parents are there to help modulate that – that anxiety. So – so the physical

understanding of it, the emotional handling of it, the younger a child, the more they're at risk.

* * *

Q All right. Doctor, the – again, we're going to the information which abortion providers think they need to get in order – information in order to have a safe abortion. Can you just – first, let's just go through what they list as what information they need, and then we'll discuss about this information.

A Okay. This abortion provider stated that the screening procedure should address these issues. The length of gestation in terms of fetal age. Is the pregnancy complicated by uterine abnormalities, multiple gestation, hydatidiform mole or other conditions. Is the pregnancy complicated by history or the presence of medical-surgical conditions such as diabetes, neurological disorders, previous cesarean section, cardiovascular disease. Is there a history of psychopathology. Can the patient comprehend sufficiently information provided, and is her decision informed and a voluntary one, and can the patient sufficiently understand and cope with her own feelings.

Q Now, in your opinion, Doctor, based upon your studies and your clinical observations of girls in the age range from 10 to 16, are they going to be competent to respond to these inquiries in a satisfactory and comprehensive manner on their own?

A No.

Q Can you explain why?

A Well, first of all, some of the conditions medically that children have, they are not fully aware of their

origins, their treatments, their management. Parents often need to provide the technical details. Second, a number of conditions that they have that are in the area of psychopathology or feelings are often accompanied by denial or distortion that we routinely rely on in any clinical encounter of having parents give their perspective on this, so there's a factual reason that – that you need other information, there's an emotional reason, and then there's a third area that is quite important, in that an unintended pregnancy is very emotional indeed, for some catastrophic event, and under the influence of anxiety a developmentally overwhelming experience leads to difficulty processing information and expressing one's self. So a frightened, anxious young child with incomplete facts, who may be withholding things, could not really give full answer to such screening procedures.

* * *

Q And you indicate – you attached to your expert report some 14 risk factors that are listed that should be evaluated prior to any abortion; is that correct?

A Yes.

Q And you list that as table 1, Exhibit C?

A Yes.

Q Could you tell us what those 14 risk factors are?

A Risk factors in – in the – table 1, low self-efficacy, expecting depression, severe grief or guilt and regret after the abortion, low self-esteem prior to the abortion, an existing mental illness or disorder prior to the abortion, significant ambivalence about the decision, lack of emotional support and receiving criticism from significant

people in their lives, perceived coercion to have the abortion, intense guilt and shame before the abortion, belief that a fetus is the same as a four-year-old human and that abortion is murder, fetal abnormality or other medical indications for the abortion, using – sorry – usual coping style is repressing thoughts or denial, unresolved past losses and perception of abortion as loss, experiencing social stigma and antiabortion demonstrators on the day of the abortion, past childhood sexual abuse, commitment to the pregnancy.

Q Doctor, do you believe that an abortion counselor could accurately assess many of these risk factors without parental involvement?

A No.

Q Can you explain why?

A Well, as I mentioned, a number of things related to medical care apply here to essentially psychiatric or emotional care. Some of the facts regarding instances of depression or past history a parent would need to provide, the child would not have, as well because of denial and coping strategies that are not atypical with adolescents, parents would have to provide a countering opinion to say that, in fact, she did have an overdose, for example, if the patient denied having an overdose. So that this is basic child and adolescent mental health, frankly, that – that one cannot get a review of the predisposing emotional factors that are comprehensive or effective just from a child.

* * *

Q Dr. Josephson, are you aware that Dr. Stotland has claimed that these studies have problems because you

can't determine whether or not the complications are caused by the unplanned pregnancy or the abortion itself. You – are you aware of her comments on that?

A Yes.

Q And are there studies that refute that assertion?

A The – again, the – the relative risk model is – is an important response to that, in that there are – clearly, an unintended pregnancy is a stress, but the event of abortion is associated with a higher incidence of self-harm, for example. I've quoted a study by Gilchrist, which is in the family practice literature in Britain, who looked at over 10,000 women who – either those who had had an abortion and those who had not, and the incidence of self-harm was much higher in that group, and so the – the – the act of an abortion is associated with increased problems, not just the idea of an unintended pregnancy. The – those that decided to abort have – have other problems, and there's more recent research that shows – by Coleman and colleagues – that women who decide to have an abort [sic] seem to have more trouble with their parenting of their young children and providing supportive environments for young children and controlling the behavior of their young children, and so – so clearly the unintended pregnancy is a stressor, but the act of abortion does seem to be associated with some problems in addition to just an unplanned pregnancy.

Q Next in your report you address mental health risks associated with adolescent abortion in section I, and you make a comment, Doctor, that sim – the simplicity of abortion is seductive to young girls of this age. Can you explain what you mean by that?

A Well, as we've discussed, adolescents tend to be impulsive and shortsighted and do not look into the future, and when one – one – one is faced with an overwhelming stress it is seductive to just be rid of it, to have it gone, to have the stress be over, and that certainly I think is present, and – and heightened with – with children.

Q Do you believe that secret abortions prevent monitoring of mental health risks that the minors may have after abortion?

A Absolutely, because the – through the secrecy it closes children not only from parents and the resources that they might provide, but public agencies who also might be able to get involved with children who are in difficult circumstances. Children who do have abortions eventually go back to homes, families find out about these things, and the secrecy then places a second burden on the children because information has been withheld, there's poor family communication, parents are angry that they have been kept out of the loop, to use that phrase, and so that secrecy never works. Delay is inevitable, which is dealing with this developmental failure and conflict, and so it's – it's never good policy.

Q Regarding mental health risks with these children, is the younger the child – is there a relationship between the youth of the child and their degree of vulnerability?

A Yes.

Q And explain why.

A Children are less able to cognitively come – cognitively understand situations. Children are less able to manage their emotions. They're less able to think clearly

when faced with a stress, and they simply don't have the facts at – at their disposal to make appropriate decisions. The – the support of parents means a lot to them.

Q And the younger they are, the more support they need? Is that what you're saying?

A Absolutely. The thing we mentioned earlier in – in my testimony, I'd like to refer to the – the abandonment of children to their own decision making is terrifying to them, and the younger they are, the more that's true. Now, adolescents tend to protest and they want it both ways, as we discussed. They want to decide on their own, but when push comes to shove, so to speak, to be left with major life decisions without input from a parent is experienced by an adolescent as an abandonment. It is not experienced as being helpful. Even if the situation is difficult, kids want their parents to know.

Q Regarding – you make a comment, Doctor, that acute stress can compromise preabortion decision making. Can you explain what you mean by this?

A Maybe the best way I can explain that is to use an example, and the example I would use would – would go like this. As a physician I have not practiced surgery for a long time, and in my training I only practiced minor surgery, but if I was asked today to take out a gall bladder and appendix, I would joke and say I've not been trained for that, I'm not prepared for that, but if I was pushed for that and somebody said you have a license, you're a doctor, aren't you, do it, my anxiety would go sky high, and it would go high because I'm not prepared or would not be prepared for the task at hand, and I would know it, and I would fear failure and fear in this case of harming someone else, and that's exactly the emotional experience of an

adolescent who has to face an adult-like task, raising or dealing with a human life that's growing within her, and have to do that without any of the preparation that an adult would have. So a child essentially is terrified of that, whether they can actually put it into words, and to have them being alone is not the way to help a decision – a decision of this import, and so the anxiety is high, they shouldn't be alone, and should get assistance with that.

Q And from your research, Doctor, have you found that even adult women have difficulty in negotiating the abortion decision processes?

A Well, I – I haven't – haven't done research on – on that myself. I think that the – the issue that – in terms of understanding and – and comprehending some of this I think can be a lot even for adult women, but certainly it's much more so than – much more so for an adolescent to understand what's going on.

Q And do you believe that parental involvement and – would help deal with the problems a minor would have in this abortion decision caused by the acute stress?

A Yes.

* * *

Q Regarding – Doctor, in your expert report you make comments regarding in certain situations where parental involvement – exceptions to parental involvement; is that correct?

A Yes.

Q And regarding these areas where there – in other words, there are certain areas where it – that the child has

a legitimate interest in not having the parents involved; is that correct?

A Yes.

Q All right. And one of these areas, would that be in a situation of incest?

A Yes.

Q Doctor, do you believe, though, that in a situation of incest is it best – the best interests of the minor to cover up the problem, the incest, abortion – incest with a secret abortion, or is it better that it be reported to the authorities so that problem can be dealt with?

A Unequivocally it's better to have it reported to the authorities.

Q So you believe it's not in the best mental health of the child for her to remain in that type of environment.

A That's right, and to have secrecy continue to persist and allow dangerous behavior, unhealthy behavior to continue, because it would only worsen and predispose the child to greater risk.

Q And in a situation where a girl says that she was afraid of family violence if she reported her – reported the fact that she was pregnant and was going to seek an abortion, is it best to place that child back into the home and cover it up by secret abortion, or should that be revealed to the proper authorities?

A It should be revealed to the proper authorities.

Q And in situations where you – the child is in a violent home and subject to violence, the fact that you

have a secret abortion, is that even going to heighten the potential of violence against her?

A Violent homes share certain kinds of characteristics, and these include volatility of temper, typically of the father, substance abuse, denial of problems, misinterpretation of the meaning of behaviors, and to come into that kind of home with the news that I've had a pregnancy and abortion and nobody knew about it would only heighten the potential for violence, so as I said earlier, secrecy, no matter how seductive it seems to be or how short term solution it seems to be, for a child is never an answer because it'll come back with a vengeance in – in violent families.

Q Regarding this issue of secrecy between child and the parent, does this undermine the parental relationship where there are secrets withheld from parents regarding their children?

A Absolutely. Now, I would add that adolescence is a time of moving from children – childhood status to adult status, and that that naturally involves an increased sense of privacy, a sense of independence and so forth, but with decisions that have major import, that are dangerous, life altering, legal involvements and these kinds of things, for a child to make them alone is – is not in their best interest at all.

* * *

Q The fact that the parents are not aware of the abortion and cannot monitor the child's mental health pertaining to suicide risk, depression, all these complications you've indicated, does that place the child's – not

only her mental health in danger, but her physical health in danger?

A Potentially, yes, it could.

Q Dr. Josephson, you've had an opportunity to read the State of Alaska's parental consent statute; is that correct?

A Yes.

Q Do you believe that the State of Alaska's parental consent statute would be in the best interest of a minor child?

A Yes.

TESTIMONY OF DR. UHLENBERG

Q Doctor, from your research and study have you come to an opinion on what happens if these laws are in effect and it causes abortion rates to go down, and what are the consequences of that, if any?

A Well, I – I think the most common position would be that abortion rates do decline after enactment of – of parental involvement laws, and so the question has been whether this would force up the birthrate, that if – that is, whether the abortion rate declines because fewer adolescent girls are getting pregnant or because they are carrying the pregnancies to term rather than abort them.

Q Doctor, have you had an opportunity to look at the – what we call the bypass provisions in our statute?

A Yes, I read that.

Q If I were to represent to you that we had a judge from Minnesota, and just telling you that Minnesota has a parental involvement statute in effect, and the judge has testified in this case that just recently the number of judicial bypass hearings that he has heard has dropped from 50 a year to about 18 a year, would that tell you anything about the possible effects on the abortion rate in that state?

A Yeah. I mean, that isn't very much information, but the first assumption would probably be that the number of abortions is going down, so the number of – of girls seeking a bypass is going down.

Q Doctor, are you familiar with the study of Dr. Ellertson on the states of Minnesota, Indiana and Missouri that is our Exhibit 119?

A Yes, I've reviewed that.

Q Doctor, could you take a look at – I think you have your own copy of our Exhibit 119, and just tell us the title of that study just for the record?

A This is "Mandatory Parental Involvement in Minors' Abortions: Effects of the Laws in Minnesota, Missouri, and Indiana."

Q And, Doctor, if you take a look at table 5, which I believe is at page 7 of our version. . . .

A Yes.

Q And looking at that, did that – what conclusion did you draw from the data that's set out in table 5 regarding the birthrates in those states that were studied?

A This suggests that the – in Minnesota the birthrate for adolescents less than 18 increased slightly – this is comparing the period immediately prior to the law with the period immediately after the law – but that increase was similar to the increase that was occurring for women who were slightly older and not affected by the law. In the case of both Missouri and Indiana – well, in the case of Missouri the birthrate for the affected adolescents increased significantly less than it did for the girls 18 to 19, and in Indiana the decrease in the birthrate was significantly larger for the under 18 than for the 18-to-19-year-olds.

Q What conclusions could you draw from this data, Dr. Uhlenberg?

A Well, that, plus the indication that the in-state pregnancy rate declined much more rapidly for the – for the under 18 than for the 18 to 19, is suggestive that one effect of this legislation was to reduce the number of pregnancies for the adolescents affected by the law.

Q And is there any indication from this study, Dr. Uhlenberg, from Dr. Ellertson's study that the birthrates went up?

A No, I think that's one of her conclusions, because this was a popular hypothesis at the time she did the study, that it would push the number of unwanted births up, and – and she did not find any evidence to support that in these three states.

Q Doctor, besides the potential benefit that you mentioned, that these laws may reduce pregnancy rates, is there another potential benefit that you considered in

forming your opinion, a potential benefit from a parental involvement law?

A Yes, I think that an important benefit that might come from this law is helping to protect the adolescent girls about – against undue influence from the boyfriends who impregnated them.

Q Okay. Before we get to that issue, though, Doctor, which we are going to get to, have you formed any opinion on whether the laws actually bring down pregnancy rates?

A I – I think there is growing evidence that they have the effect of reducing pregnancy rates.

Q And that's in addition to not having an increase in birthrate.

A Yes.

Q Doctor, could you take a look at No. 2259, which – our number, which is your – you should recognize it as your expert report, but we'll see if you do?

A Yes.

Q And in No. 2259 did you set out some research that you had done in the area of pregnancy rates as related to parental involvement laws in other states in the country?

A Yes. In a rather simple way I looked at – compared Mississippi before and after the enactment of a parental consent law there with the neighboring states that all – each of those states already had a parental involvement law in effect.

Q Okay. Can I stop you just for a moment, Doctor? Just so – for the record, we're looking at page 18 of your expert report, which is headed table 1. Is that. . . .

A Yes.

Q . . . . what you're looking at?

A That's correct.

Q Okay. And what did you compare, sir?

A This is a comparison of girls affected by the law, that is, 15-to-17-year-olds, with the girls slightly over 18 to 19 who were not affected by the parental consent law.

Q And what conclusions did you reach after – well, first of all, sir, where did you get your data for this?

A This is coming from a publication from the Center for Disease Control called the mortality and morbidity weekly report.

Q Okay. And what conclusion did you draw from doing this – making out this table, looking at that data?

A In this case the – there are two kinds of comparisons, the pregnancy rate for 15-to-17-year-olds between 1992, and 1994, which the law went into effect in 1993. So I'm taking the year before and the year after the law went into effect, and the pregnancy rate for the girls affected in Mississippi declined substantially more than for any of the neighboring states. In fact, in two of the neighboring states the pregnancy rates increased in this time interval. The second comparison is the 15-to-17-year-olds with 18-to-19-year-olds in the same state, and, again, the pregnancy rate for the affected girls declined more than the pregnancy rate for the older girls.

Q Dr. Uhlenberg, did you also look at a study conducted by Dr. Rogers of the effects of the Minnesota parental involvement law?

A Yes, I've reviewed that.

Q Okay. Sir, if you'd take a look at what we're calling Exhibit 120, and do you have that in front of you?

A I do.

Q And what is that, sir?

A "The Impact of Minnesota Parental Notification Law on Abortion and Birth."

Q And it's by Dr. Rogers, and then several others; is. . . .

A That's correct.

Q . . . . that correct? Sir, what – if we look at page – let's see, 296, I think it's – we have it numbered as page 3, and what did Dr. Rogers conclude regarding the birthrates of the group affected by this parental involvement statute, the 15-to-17-year-old group?

A He concluded that the decline in the birthrate for 15-to-17-year-olds and 18-to-19-year-olds was much greater than for the rest of the adult population in the state.

Q And did he make a comparison between the decline between the affected group of 15 to 17 and the older group in Minnesota?

A Yes, that it was a – a significantly greater decline in the birthrate for the 15-to-17-year-olds.

Q What did Dr. Rogers conclude was the possibility – a possible explanation for that?

A I think that his conclusion is that the enactment of this law led to a – first of all, to a decrease in abortions, but then also the – at least no positive effect on the birthrate; that is, the birthrate for the affected girls continued to decline, and perhaps more than it would have otherwise, suggesting that the pregnancy rate was declining.

Q Okay. Dr. Uhlenberg, if you'd look at page 296 there under discussion, and the middle of that first paragraph, and in there does Dr. Rogers suggest a possible reason why the birthrates fell and the abortion rates fell?

A Well, his – his conclusion tends to be the birthrates fell in keeping with the long-term trend, that is, the birthrates were already declining before this law was enacted, but the abortion rates fell markedly for the age group affected, and he sets out several possible explanations, which he then. . . .

Q Okay, what. . . .

A . . . . says run. . . .

Q . . . . is – what were his possible explanation?

A He said that one possibility is that minor women who were affected by the law were going out of state to obtain their abortions, and so were not reported in Minnesota, or others – concerns would be with growing concern over the hu – human immunodeficiency virus infection.

Q And did he suggest a possibility that you agree with a little more than those?

A Yes. He says that because of the very rapid decline in number of abortions it doesn't seem likely that other explanations could account for it, except possibly going out of state, but then he cites a reference that suggests that it's very unlikely that many girls from Minnesota would have gone out of state for abortions because of the distance to abortion providers out of state.

Q Dr. Uhlenberg, if you'll look at page 296 in the paragraph labeled discussion, in the middle of that paragraph, the sentence beginning with "one possibility," and could you read that to us, please?

A One possibility is that when minor women are restricted from abortion without notifying parents or seeking court approval, and are geographically prohibited from easy access to out of state abortions, they're more likely to take measures to avoid pregnancy.

Q Dr. Uhlenberg, do you di – agree or disagree with that conclusion as a possibility – being a likely possibility?

A I agree that that's a likely outcome.

Q Dr. Uhlenberg, can you see or do you see that there might be an effect of pregnancy abor – of waiting because of parental involvement law if a minor is faced with perhaps a second pregnancy?

A Yes, I think if the parent is aware of an earlier pregnancy, there is a likelihood that they will intervene more significantly with the – the child and attempt to help her avoid an additional pregnancy.

Q Dr. Uhlenberg, could you take a look at exhibit – what we're calling Exhibit 121?

MS. NOVAK: Your Honor?

THE COURT: Yes.

MS. NOVAK: We have an older version in the binders, and I have a newer version of this study that matches Mr. Doogan's copy. If I could approach I could bring it to the witness and to Your Honor.

THE COURT: I already have in my binders the substitute version.

MS. NOVAK: Oh, you do.

THE COURT: That's right, but if you'd like to show it to the witness. . . .

MS. NOVAK: Okay.

A Thank you.

Q Do you recognize the document itself, though, what we're calling No. 121, in either version there?

A Yes, I – I think I've reviewed both versions, so. . . .

Q Okay, and what is that, sir?

A The – a long title. "The Impact of Mandatory Waiting Periods and Parental Consent Laws on the Timing of Abortion and State of Occurrence Among Adolescents in Mississippi and South Carolina."

Q Okay. And if you could turn to table 1, and I think it's on page 270 in our new version here.

A Yes.

Q And, Dr. Uhlenberg, did you look at this table and give it some consideration before today?

A Yes, I have.

Q And what do the data in the table on table 1, what do they show?

A For Mississippi it – it shows that the number of abortions occurring to residents of Mississippi who were eight – 18 and younger declined 14.3 percent in the 10 months after the enforcement of the parental consent law, compared to the ti – 10 months preceding that.

Q Now, was there a difference that the authors noted between some of the requirements of the South Carolina and the requirements of this Mississippi law?

A Yes, they state that the Mississippi law is probably the most stringent law in existence, and that it requires the consent of two parents.

Q And is there also a delay law built into Mississippi's?

A That occurred not exactly at the same time, but within a year or so of the parental consent law there was a – an informed consent and mandatory waiting period law that went into effect.

Q And what was the effect from table 1 that was shown on South Carolina minors?

A For South Carolina the – the decline in number of abortions to resident minors was even greater, a 19.3-percent decline in the 10 months after compared to the 10 – 10 months preceding.

Q And what are possible explanations for the decrease in the number of abortions for minors in Mississippi from this study?

A Well, the – it again could – you could see a decrease in the number of abortions if an increasing proportion of these girls were carrying the pregnancies to term, that is, having live births instead of abortion after the law was enacted, or you could see a decline in the number of abortions if – if fewer pregnancies were occurring.

Q Was there any evidence from the study that the birthrates increased?

A There was no significant increase in the birthrate after these occurred, after the law was enacted.

Q Dr. Uhlenberg, did you consider the possibility or not consider the possibility of minors in Mississippi traveling to other states as a result of the law to obtain abortions?

A Yes, that's at least partially reported in the – table 1 in the Dr. Joyce paper.

Q Okay. And how likely or unlikely is that to account for all of the drop in the abortion rate?

A Well, the decline in the – the large decline in number of abortions were in-state abortions. The number of girls going out of state for abortion increased by 23 in the period after compared to the period before.

Q So there could be a 23 – is that a number or percent?

A That's a – a number, 23 – increase of – of 23 girls going out of state for abortion in the 10 months after the law was enacted, compared to the preceding 10 months.

Q Doctor, could we take a look again at 2259, which is your expert report, and what we call table 2 at the end

of that? And that would be on page – I'm looking at page 19 of your expert report.

A Yes, I have that.

Q And what is that, sir?

A I found three states that during the 1990s enacted parental consent laws similar to Alaska, not identical to Alaska's, but requiring consent of one parent. They differ in that they also affected 17-year-old girls instead of only the – the younger ones. So I compared the pregnancy rate before and after the laws were enacted in these three states, compared the pregnancy rate for 15-to-17-year-olds with the change in pregnancy rate for 18-to-19-year-olds in the states.

Q And what conclusions can we draw from this table 2, dir?

A Well, in each of these three states the pregnancy rates for 15-to-17-year-olds declined substantially in the year after compared to the year before, and the declines were much larger than they were for women age 18 to 19; that is, the closest age group not affected by the law.

Q Okay. In Kentucky what – how much greater, approximately, was the decrease in pregnancy rates for the affected group?

A Would be about six percent larger decline for the 15-to-17-year-olds.

Q Okay, and how about Pennsylvania?

A Pennsylvania would have been about a 10-percent greater decline for the 15-to-17-year-olds.

Q Okay, and then how about Michigan?

A Michigan would have been approximately 11 percent greater for the 15-to-17-year-olds.

Q And, Dr. Uhlenberg, can you draw a conclusion from looking at this table 2, or did you draw a conclusion as to whether those laws had any effect?

A Yes, the conclusions are always tentative, but, you know, this is – they support the argument that pregnancy rates decline after enactment of a parental consent law.

* * *

Q Dr. Uhlenberg, if a minor who is faced with an unexpected pregnancy is required to tell her parents about it because of one of these laws, will – in your opinion might that have an effect on her future sexual activity and fertility activity?

A Yes, I think by having the parents involved in the decision of what happens after the first pregnancy, at least some parents are going to more actively monitor their child's behavior and perhaps restrict her dating behavior and this sort of thing.

Q On the other hand, if a parent doesn't know about the first pregnancy, what, if anything, could that parent do to affect their child's avoidance of another one?

A There would be – if the parent is unaware, then they are not going to be able to change their monitoring, probably, of the adolescent, or they'd be no reason for them to change their monitoring behavior.

Q Dr. Uhlenberg, did you see any effect of this law on the actual involvement of parents in the lives of their minor daughters?

A I think that in some cases it probably would lead to an improvement in the relationship in the sense that the support of the parents as the girl goes through a difficult decision would be viewed as strengthening the relationship with the parent.

Q Doctor, do – can you – do you this law or not as requiring, as mandating, as forcing parents to be involved in their daughters' lives?

A Well, because of the possibility of judicial bypass, some girls could avoid involving their parents, but for – as I understand the law, it would require the consent of one parent before the girl could have an abortion.

Q Would that. . . .

A With – with – without. . . .

Q I'm sorry.

A . . . . the judicial bypass, of course.

Q Okay. However, do you believe or not that this is a guarantee that parents will sit down with the girl and talk over the things that led to her being pregnant and wanting an abortion and so on?

A No, we can't achieve that by law. We think it can influence or facilitate that, but it doesn't necessarily lead to that outcome.

Q Doctor, what effect in your opinion do families or parents have on the various health risks that face minors? For a moment just exclude abortion, exclude pregnancy.

A Well, the research is quite – quite strong on this in – in suggesting that probably the most important factor affecting adolescent well-being is the family context that – that they live in, and within family context it's that relationship with parents, involvement of parents in the lives of the children that tends to protect children from harm.

Q And does that include protecting them from health risks that they might otherwise face?

A Yes.

Q Dr. Uhlenberg, if you took a look at No. 2137, please. . . .

A Yes, I have that.

Q And I think you have that before you. Could you tell us what that is, please?

A This is entitled "Protecting Adolescents from Harm: Findings from the National Longitudinal Study of – on Adolescent Health."

Q Okay. What is the national longitudinal study of adolescent health or on adolescent health?

A This is the most ambitious study of adolescent health and sexual behavior ever undertaken. It involved surveying approximately 90,000 adolescents, middle school and – and high school students, and then the longitudinal part of it is that they have followed up with a subsample of this initial sample.

Q And, Dr. Uhlenberg, did the study look at various behaviors by minors that could lead to health risk?

A Yes, it looked at a number of – of factors affecting health.

Q Okay. Dr. Uhlenberg, if you look at page 830, please, of that study, of 2137, on the right-hand column there there's a heading that says history of pregnancy. Do you see where I am?

A Yes.

Q And in this part of the study did the authors reach any conclusion about protective factors against a pregnancy by minors 15 and older?

A Yes, they say that – if – if I could read one sentence here: A greater number of shared activities with parents, and perceived parental disapproval of adolescents' contraceptive use were protective factors against a history of pregnancy.

Q What does protective factors mean; what did that phrase mean?

A They're trying to assess the factors that would lead some adolescents to not engage in sexual activity compared to others.

Q Okay. Doctor, you mentioned before another benefit of the – that you saw in the law regarding the partners of minors. Would you state that again, please? What benefit did you see from the law regarding minors' boyfriends, if any?

A Well, there was substantial concern about the coercive influence of older boyfriends on their younger

girlfriends, and this comes up both with regard to violence in the relationship, as well as decisions of a girl regarding – well, affecting the likelihood that a girl would become pregnant, and, if so, the outcome of that pregnancy.

Q What factors might influence a – an adult boyfriend of a minor female in influencing the – first of all, the – well, the – influencing the outcome of a pregnancy?

A Well, I think the incentive or – of adult males for not having the pregnancy result in a live birth are the increased child enforcement activities – child enforcement – the child support requirements of men who are fathers of children who are born.

Q Dr. Uhlenberg, is it always true in your studies in this field that the boyfriends or – adult or not – of minor females who become pregnant, is it always true that they involve themselves in the outcome of the pregnancy; that is, deciding what happened?

A No, I'm sure they don't in all cases.

Q Okay. Doctor, if there was – well, let me withdraw that and ask it this way. Are you aware of data that concerns the type of adult input that a minor faced with a unexpected pregnancy gets on pregnancy resolution?

A Well, I've reviewed the study by Dr. Henshaw that talks about that.

Q Okay. If you take a look, then, at No. 123. . . .

A Okay.

Q . . . . and is this the study you just mentioned?

A Yes.

Q Could you tell us for the record what the title is, please?

A "Parental Involvement in Minors' Abortions Decisions."

Q And turning to table 8 in that, which is at page 205, at least the printed page number. . . .

A Yes.

Q . . . . you're familiar with that data?

A Yes.

Q And, Dr. Henshaw, what does that data indicate for girls 15 and younger in this study where her parents – neither parent knew of the pregnancy, who was involved most often in the decision regarding the pregnancy?

A Okay. There was a slight slip. I'm not Dr. Henshaw, but. . . .

Q I'm sorry.

A . . . . I'll – I'll respond for myself.

Q Yes, I'm sorry. Yes, Dr. Uhlenberg.

A When neither parent knew of the abortion and the girl was under age 16, the – the most common person involved was the boyfriend. That was in 93 percent of the – the cases.

* * *

Q Okay. Had you read the original study by Dr. Males and Dr. Chew that – regarding this subject?

A Yes, I've read that.

Q And do you agree, then, having read that other study, with the conclusion that Dr. Males states in this commentary?

A Yes.

Q Could we turn to that one, 2098? Should be our exhibit number. And what is that, Dr. Uhlenberg?

A "The Ages of Fathers in California Adolescent Births, 1993."

Q And was that a large – you – you've read this study before; is that correct?

A Correct.

Q And this is a document that was referenced in the commentary that we just looked at?

A That's correct.

Q Or the study. Was that a large study or a small one?

A This was a very ambitious study looking at 46,000 California births to school age mothers in 1993.

Q Dr. Uhlenberg, if you could look, please, then at table 1, which looks to be on page 566 of that document?

A Yes.

Q And what does that table show regarding minors who gave birth, first of all, nationally – well, first of all, does it break down the data between the United States generally and the state of California?

A Yes, I see that.

Q Okay. Does it – could you tell us what this table shows regarding the age of the fathers – or the percentage of fathers of children born to minors 10-to-14-years-old in the United States during 1992 to how many were in the 20-to-24-year age range?

A Yes, in the United States 24 percent of the fathers were girls age 10 to 14. . . .

Q And then. . . .

A . . . . or age 20. . . .

Q . . . . how about in California?

A In California it was 27 percent.

Q And then looking at the age group, 15 to 17, which is – includes the group would be affected in Alaska, but actually includes a little more than that, what was the percentage of fathers 20-to-24-years-old for girls in that age group who gave birth nationally?

A It was 40 percent.

Q And then how about California?

A Identical, 40 percent.

Q And, Doctor, is that a matter of concern from a sociological standpoint; that is, from the sociology of the family? Is that a matter of concern, or should it be?

A Well, we need to separate concern about social problems from sociology. Sociology would tend to be a scientific investigation which doesn't come to a conclusion about whether something is good or bad, but the sociological data are then used, and, of course, researchers

themselves have positions with regard to whether these are desirable or undesirable kinds of findings.

Q Doctor, if you could look at the – on that page 566 where it says results?

A Yes.

Q And apparently is it correct that the authors of the study used a couple of different approaches to determining the figures that they came out with?

A Yes, I think. . . .

Q What were those?

A Well, because some fathers' age was not stated on the birth certificates, they used what they call upper and lower boundary to estimate how many of the fathers would have themselves been over age 20 or have been adults.

Q And did it reach a conclusion on – did they reach a conclusion in that paragraph on the numbers of fathers – or, actually, the percentage of births to fathers who were pre – pardon me – postschool adult men where the mother was 17 years old?

A Yes, this says that the low estimate would be that 66 percent of the infants born to 17-year-old mothers were fathered by men age 19 and older, and it may have been as high as 76 percent. They can't tell within that range, but it's. . . .

Q And then how about for 15-year-old mothers at the bottom?

A For 15-year-old mothers 47 percent of the infants would have been father – fathered by postschool adult

males under the lower estimate, and 63 under the upper level.

Q Dr. Uhlenberg, could you please turn to No. 147 next, and that's our Exhibit 147.

A Yes.

Q And what is that please?

A It's entitled "Age Differences Between Sexual Partners in the United States."

Q And who is the principal author there?

A Darroch, D-a-r-r-o-c-h.

Q And have you read this study before and considered it?

A Yes, I've reviewed this.

Q Okay. If we turn to table 1 in this study, No. 147, table 1, which is, let's see, page – I think I have a page here – looks like 163.

A Yes, I have table 1.

Q Okay. What does the data in that table show regarding the age differences between women – well, first of all, let me withdraw that, and for purposes of clarity, is this a study where they actually act ab – ask about not necessarily pregnancies and births, but about sexual activity itself?

A Yes, these tables come from several different sources to – to make estimates, and one source is a survey giving information on what they call romantic relationships by age.

Q Okay. And table 1, is that the one that deals with the sexual partners of the women and girls that are shown there?

A Yes, this is having had sex in the previous three months by difference in age of partners.

Q Dr. Uhlenberg, in the 15-to-17 age group for the females what did the study show – or the – what does table 1, the data show the percentage of those who had sexual partners who were at least three and up to five years older?

A Shows that about 35 percent of the male partners were three or more years older than the 15-to-17-year-old girls.

Q Okay. And does that include about 30 percent in the three- to-five-year age range?

A Yeah, that's 29 percent.

Q And then close to seven per – or 6.7 percent had partners who were six or more years older; is. . . .

A Yes.

Q . . . . that correct?

A That's right.

Q And so then we have a total of what percent had partners at least three years older?

A Rounded off, that would be 30 – 35 percent – 36 percent, I'm sorry.

Q Dr. Uhlenberg, if you'd turn to page 164, and in the text there under table 2 did the authors conclude

whether there were differences or not – and, I'm sorry, do you have the same copy I do? It's the printing under table 2, and it's in the paragraph. . . .

MS. NOVAK: I think you meant page 164. You might have said 174.

Q I'm sorry, 164. It's part of the findings. Okay.

A I'm not sure. The page numbers are. . . .

Q All right.

A . . . . cut off on my copy.

Q Let me just give you my copy, then. You have different page numbers on yours.

A Well, they're cut off for some reason. Okay.

Q Did the authors of that study, then, make any conclusions about differences in the pregnancy rates for those minors who had older partners?

A Yes. For the girls who had older partners the pregnancy rates were higher than for the younger girls.

Q Okay, specifically for the age group younger than 18 what did they report as the pregnancy rate by age of father – or age of sexual partner?

A Okay, the – the pregnancy rate for under 18-year-old girls whose partner was younger than two years older than themselves was 176.6, and then it goes up for girls where the partner was six or more years older to 653.8.

Q Okay, Doctor, in the text there. . . .

THE COURT: I'm sorry, Doctor, I. . . .

Q .... did they break that down?

THE COURT: .... I lost you.

MR. DOOGAN: Okay.

A Okay.

THE COURT: I'm not sure exactly where you are reading from?

MR. DOOGAN: May I approach?

THE COURT: Yes, you may.

A I'm on table. . . .

THE COURT: If you look at the text at the bottom of page 164, and actually it's the highlighted portion.

THE COURT: No, the doctor was referring to some numbers and. . . .

Q You're referring to. . . .

A I was. . . .

Q .... what?

A .... reading from the table.

THE COURT: Okay, table 2. Where in table 2 did you read those numbers so I can track?

A This would be pregnancy rate on the. . . .

THE COURT: Uh-huh. Okay.

A .... left-hand column, the less than 18-year-olds, and then you have total, you have for younger to two – where the partner is younger than two years older. . . .

THE COURT: Okay.

A .... up to six or more.

Q And from the text, though, at the bottom of that – under that table on 164, what did the authors conclude?

A Yes. Based on those numbers the conclusion is that for adolescents younger than 18, the pregnancy rate among those whose male partner was six or more years older was 3.7 times the rate among those whose partner was no more than two years older.

Q And then how about for those whose partners were three to five years older?

A Yes, that's intermediate. The rate for those whose partner was 3.5 years older was 1.4 times as high as for the ones where the partner was less than two years older.

* * *

Q Yeah. Dr. Uhlenberg, just – look at figure 3, which is the chart.

A Yes.

Q And just below that is there some indication of a percentage for which the age of the father was not known from birth certificate records?

A Yes, it says it was not known for 24 percent of the births, the females age 13 to 19.

Q Okay. Doctor, turning back to page 4, in the text next to table 1, is there a conclusion for the mean ages of the – mean age of the father for whom age was listed on a birth certificate for the age group less than 18 years – for the mothers who were less than 18 years of age?

A Yes, reading from that paragraph it says: For births to women less than 18 years of age, the mean age of the father was 24.5 years, and 84 percent of the fathers were over 20 years of age.

* * *

Q Is minors', in your opinion from – you go to the minor and you go to the family – is minors' reluctance or fear to tell their parents about an unplanned pregnancy and perhaps a desire for abortion a good reason not to have a law such as the parental consent act?

A No, I think that generally we agree that parents have a right to know what is going on in the lives of their adolescents, especially in terms of behavior that has significant implications for the adolescent.

Q If there is forced knowledge – we'll call it forced knowledge – an initial response of parents, though, is anger and disapproval and disappointment, do those responses, in your opinion, disqualify those parents from further involvement in the minor's decision about her pregnancy?

A No, I think we find that those emotional responses are common in families for different circumstances and they are not considered a indicator of dysfunction in a family.

Q Okay. Would those kinds of responses, initial responses, make those parents a threat to their daughter's well-being?

A No, those respon – emotional responses by themself would not be threatening.

———

TESTIMONY OF DR. CALHOUN

Q Doctor, Dr. Richey brought to the Court's attention a variety of what she represented to be life-threatening conditions that a minor might eng – might become involved with in prenatal care. What I would like to ask you is just how frequent these conditions are, and explain to the Court regarding preeclampsia. How frequent – how likely is a girl who's 16 and under to actually be faced with a decision regarding this?

A The – the statistics are – are different depending on population groups, but somewhere between 7 and 15 percent of patients may develop preeclampsia. However, the – the risk of developing severe preeclampsia, meaning severe enough that it caused you to be devel – deliver before 37 weeks is probably less than one or two percent, and those are not life-threatening forms of preeclampsia and actually respond well to delivery, and would actually be part of the normal prenatal care that anyone would receive, including those who are not adolescents.

Q Regarding this trisominy [sic] – tri – correct my mispronunciations.

A Tri – trisomy.

Q Trisomy 18, how fre – how frequent is this likely to occur?

A Trisomy 18 is actually quite rare, and also extremely rare in those who are adolescents. The care for someone in that particular situation is the same as the prenatal care for anyone else. A trisomy 18 is not a diagnosis that places the mother's life in danger.

Q And the insmimenger [sic] syndrome is. . . .

A Eisenmenger syndrome.

Q Eisenmenger syndrome, yes.

A I don't know how to spell that, so I'll have to use the – what you have previously. Eisenmenger syndrome is actually very rare. It is a complication of specific complex cardiac defects that are not very common anymore because we correct most of the problems that used to lead to this. If, indeed, that were the case, again, medical therapy is indicated and you would treat this patient as you would treat anybody else who had a significant medical problem and was pregnant.

Q How about severe diabetes that would cau – in this age group that would cause pregnancy complications?

A In the under 16 severe diabetes is not that common, for the most part because the patients have not lived long enough to have enough time to develop most of the serious complications related to insulin-dependent diabetes. However, if there were complications, again, you would treat the patient, give them the appropriate therapy, and would treat them much as you would treat another woman, with the idea that they are adolescent

and would require some special care in the clinic and oversight with their parents.

* * *

Q Doctor, in your 20 years of experience in dealing with these hundreds and hundreds of girls who are in high-risk pregnancy situations, how many girls have you lost as a result of a – the – a fetal condition that actually died during delivery?

A None of them have.

Q In your opinion, Doctor, after 20 weeks is abortion safer or is delivery safer?

A Well, if you read the – if you read the textbooks, including Dr. Grimes' text, delivery after 20 weeks is actually safer than doing D & E's or deli – or abortions after 20 weeks, and there's no benefit to the pregnancy anyway.

* * *

Q Doctor, in your opinion is one of the risk factors in an abortion the skill of the particular provider doing the abortion?

A Yes. In fact, every surgical procedure the risk of complication is directly related to the skill of the operator and the training of the operator.

Q And do you believe that parents would be valuable assistance to children picking out competent doctors to perform abortions?

A I think that they're – most 16-year-olds or 15-year-olds are totally unaware of the fact that most states do not require abortionists to be obstetrician/gynecologists or

have any training whatsoever in gynecology, and that parents would be able to give them that information and direct them to people that were competent providers. I don't think most 14- or 15- or 16-year-olds would be medically sophisticated enough to be able to do that, and would – would really need their parents' input and involvement to provide that care.

Q Do you think parents are needed for these girls in order for these girls to understand what is going to happen to them and to give an informed consent?

A Yes, I do. I think the parents have to be involved and hear it.

Q Doctor, do you think parents are needed to help their children monitor their condition during the abortion procedures?

A I'm not sure I understand the question.

Q Well, let me give you an example. In a situation where a child is being – going through a two-day abortion procedure and the abortion doctor has inserted the Laminaria and requires the child to come back the following day, do you think it's important to have parents aware of that so they can ensure that the child returns for that treatment?

A It is imperative that they understand that, for if the patient happened to be doing it in secret and the parents and the – the adolescent left to go someplace on a vacation or left to go somewhere, there are risks for infection, toxic shock, bleeding, and/or other complications if it's not – if the abortion's not done appropriately and supervised by the parents appropriately.

Q In your experience in dealing with these minor children over 20 years how – just how reliable on their own are they in following medical care instructions?

A Adolescents are notoriously unreliable, frankly. They are very difficult to get to do things, they are very difficult to get to appointments sometimes, and we rely very heavily on their mothers and fathers and family members to really help get them to appointments, to help get them scheduled for ancillary consultants, to help them get them to our appointments for ultrasounds, to make sure that they're taking their prenatal vitamins. All the things that go on with prenatal care, we rely on the family. Adolescents most of the time just are not really very good about that.

Q And regarding the parent – necessity for parents getting involved in monitoring their children's care for postoperative complications from abortion, do you think that it's necessary to have parents involved in that for the safety and health and welfare and benefit of these children?

A I think the parents have to know any surgical or operative procedure that's been done on their child, particularly an abortion, which does have complications of bleeding and infection, including toxic shock and/or severe complications related to the abortion, just like I would a cesarean section. I'd want them to know those so they could monitor the patient and take good care of them and bring them back for follow-up.

Q And if a child delays in getting treatment for abortion complications, can this have severe consequences?

A Yes, there's been many – many case reports of delay of di – diagnosis and young women bleeding to death and/or becoming seriously infected, and my own experience of having to have hysterectomies and complete loss of their reproductive capabilities. I've had them be in toxic shock because of secret abortions and because of the lack of follow-up by their family. So, yes, I think it's imperative that they have their family members or people involved to help them get the postoperative care they need.

* * *

Q All right. Now, what's the youngest pregnant patient that you've ever had?

A Ten years of age.

Q Did she deliver?

A Yes, ma'am.

Q And how many 10-year-olds have you seen?

A How many have I seen personally?

Q Yes.

A For sure one, and several 11-year-olds. I couldn't tell you how many 11-year-olds.

* * *

Q Let me ask the question – break it down a little bit. I used the term elective abortion in my question.

A Uh-huh.

Q How would you define an elective abortion?

A I think the elective abortions are those that are done not – for not medical indications, and basically in my mind to save the life of the mother is an elective abortion.

Q Okay. And I don't think, though, you ever got to the – my final part of my question, which was do you think that parents who actively support their daughter's decision to have an elective abortion are acting in her best interests?

A When I look at the literature I don't think they are, but they probably think they are.

Q Now, it's your opinion, isn't it, Doctor, that the vast majority of abortions for minors 12 to 16 are not medically necessary, correct?

A Yes, that is true.

Q Okay. And can you define again what you mean by medically necessary?

A Well, I think I did, but I'll repeat it. Those that are done to save the life or protect the life of the mother are the medically indicated abortions that I'm talking about.

* * *

Q Do you agree with Dr. Isada's position that he believes that the procedure Dr. Richey's doing by doing D & E procedures without using ultrasound is an unsafe procedure?

A Yes, and it has been for probably 15 years. We all use ultrasound even for the basic dilatation and extractions or D & C's.

Q So her own partner believes that she's engaging in substandard practice, at least in that area; is that correct?

A Yes, sir, if that's what he – if that's what he said, yes, sir.

TESTIMONY OF DR. ANDERSON

Q What has been your observation regarding adolescent girls 16 and under in terms of their responding to and dealing with abortion complications?

A Adolescent girls, most of the time denial is the biggest issue and fear. If they've been engaged in high-risk behavior, which we define sexual activity, drug addiction and suicidal issues as, that's something that they're not wanting everybody to know about, and so if you had a girl who's become pregnant and the become – had an abortion, they are hoping this whole process will end as soon as possible, and the abortion doctor will tell them you're going to have pain and you're going to have bleeding as a normal complica – not a complication – as a normal part of the process, so when they have some bleeding or some pain they're equating that with this is going okay, this – and that denial issue means I don't want to think that I'm out of the realm of normality. This is going to be over soon, I'm going to finish it. And then if things don't get better and they come in, it's really after a longer period of time because of that denial, and now the fear is this whole process is not ending, it's continuing, going on. So those are predominant issues, as well as a sense of wanting to hide, being ashamed of the – the process of the abortion – not everyone, but a percentage.

* * *

Q Okay. Let's just focus on parents for a second. Sounds like your experience is some of the parents who

show up at the ER with their daughter for an abortion-related complication knew beforehand that she had an abortion, and that's why she's coming, for a complication related to that or they think it's because of that, and some of them learn for the first time that she had an abortion at the ER; is that correct?

A Yes.

Q Can you tell us your observation in terms of parent-daughter interaction that you've observed in both of those contexts?

A Well, the – if – there – there's kind of three different circumstances. If the parent knew about the abortion prior to the abortion, they are brought there sooner, and the focus is on now the appropriate treatment, what do we do, just go help my daughter, how serious is she and what – what's our next step. Now, if the child's been at home and they're not getting better or the pain's getting worse, they might inform their parents at home after a 10-hour or a 12-hour period from that time of first having symptoms to the time that the child is really getting scared, listen, I had an abortion, and that parent will arrive with new information about their daughter, but it's not early, but still the focus is what now can we do, they've had some [sic] to process that information. And the third group of patients that I've had to deal with is parents who I've had to tell them your daughter is sick because she's had an abortion and we need to have an obstetrician see her about further treatment, whether it's a D & C to help stop the bleeding, and so now they're not only focused on how sick their daughter is, they've got to deal with the issue that she was pregnant and the implication that has with it as far as sexual activity and the disappointments there, they

have to deal with the fact that their daughter's had an abortion, that she was really hiding from them, and just the sense of disappointment and trust issue there. So you're dealing with really conflicting emotions. My daughter's sick, but I've added all these other issues in with the primary focus of my daughter being sick, and so they're trying to process a lot of information in order to make a good decision, because I need their permission to involve a doctor to do the D & C if it's bleeding, or admit them to the hospital and start IV medical antibiotics.

Q Now, staying with that last group of parents, all the things that you've just described for us that that parent is dealing with, having learned for the first time their daughter had an ER [sic] because you told them, what are the reactions you've seen from the parents in that context?

A Well, certainly, embarrassment if this stranger, i.e., myself, is telling them something about their daughter that they don't know, that's – many times that I as a parent when people have had to tell me some report about one of my children, you're just embarrassed. You're dealing with the shock of the behavior that's involved and the disappointment there, and – and that's – they have to process that, and sometimes they have to work through the disappointment and anger, but they always generally reconnect. They'll come back, okay, now I've processed this, I've been through this, but let's focus on what I need to do now. So give them some space and talking with them, they'll come to focus on the appropriate next step. We've got to do something that's going to be in the benefit of your daughter's health care. So they will reconnect.

Q Okay. Staying on that last group of parents, how many times in the course of your experience as an ER physician dealing with these sorts of situations have you in your observation of the parent-child interaction had a concern that that girl might go home and be abused by her parents?

A I've not.

* * *

Q Have you had occasion to see young girls 16 and under who have come to your ER, but have delayed coming to the ER for care related to an abortion complication?

A Yes.

Q How prevalent is that?

A That – like I said, the complications of abortion run in between anywhere from 10 to 20 a year, and because of this high-risk behavior of that patient population, parents aren't involved. I mean, kids don't go out and tell their parents I'm going to be sexually active or I'm going to go out and get drunk tonight, and so even from the inception of that activity parents aren't involved, so I would say 10 to 20 a year, which three to five a year being an extreme condition, and the others we're able to treat and I don't involve them in – I don't involve the parents. I still can't involve the parents on the kids that aren't super sick unless they give me their permission so I can treat them, tell them to watch out – what to watch out for and discharge them.

Q Can you distinguish in your mind – focusing on the issue of delay that you've discussed, can you distinguish in your mind – maybe I should phrase it in terms of

the timeliness in which a young girl might seek care at the ER for an abortion complication. Can you distinguish in your mind between those who have parents who knew about the abortion and those who learn for the first time at the ER?

A Yes.

Q Please do.

A The complica – the parents who know about the abortion are much quicker to bring the patient to medical care. That – we just see that parents act much quicker than kids do and are more decisive on all the areas of decision-making process because they have, I mean, experience, as well as they're abstract thinkers versus concrete thinkers. I mean, it's a whole host of issues. But the parents who are involved are much quicker to get interventional care.

* * *

Q What are the possible consequences of delayed medical treatment for an abortion complication?

A Well, delayed treatment can make death if infection spreads out of the fallopian tubes into the bloodstream of – a higher possibility or potential. It can make sterility if the ut – infection has spread up the uterine cavity, out the fallopian tubes, but not into the bloodstream, you see the chronic – the scarring of the tubes causing sterility. If bleeding is excessive, then you're dealing with underperfusion of organs, whether it be brain or heart or kidneys, and that can have implications or possible death, and if there's perforation of the colon after perforation of the uterus, that delays – delay of treatment – I mean, the thing that it happened is catastrophic. Delay of

treatment is catastrophic as far as seeding for a sep – I mean, in infection and/or bleeding.

And the last one is depression or psychiatric. Kids – I think all of us who've raised adolescent children recognize that they begin to develop their own world, their own identity, and they pull out of the adult relationships somewhat, and they don't communicate as much, so we're not as quick to pick up on depression because we're not really seeing how sad they might be. So I've – probably my largest population of postabortion complications is suicide ideation and depression and/or suicide attempts, and that's not short term, nor long term. It's over a whole time period, because that guilt sometimes just seems to persist and persist, and the girls just can keep stuffing it and stuffing it, and so we don't see that as a short-term complication. If the parents don't know to – to recognize it they might say, well, my daughter's just withdrawing like such and such daughter, they just don't communicate with me much, where in actuality they're really dealing with a depressed teenager.

Q We'll talk about the emotional issues in a second, but for now can you tell me how long a young girl has to delay treatment for an abortion complication before some serious sorts of issues can ensue?

A I would say four to eight hours.

Q Four to eight or 48?

A Four to eight. . . .

Q Four to eight.

A . . . . hours. If she's bleeding heavy, we don't even want them bleeding heavy four hours. I mean, you can

bleed down – thankfully, that – that's not the case, but if you're dealing with infection, we see infection spread – I watched an appendicitis patient come into the emergency room and they'll go in a matter of three to four hours from a mild appendicitis to a significant appendicitis and need surgical intervention, so an infection can spread quickly, and bleeding if it's heavy can be compromising very quickly.

Q Okay, now, what about uterine perforation?

A That would be a matter of hours, because if you perforate the uterus the intra-abdominal cavity is sterile, and so you've given access for bacteria from the vaginal vault, and if there's a perforation of the colon, from the colon into the intra-abdominal, and we can see them go from seeding to bloodstream infection four to eight hours.

Q Now, the source – you're talking about bleeding. The source of this bleeding, heavy bleeding that might be a complication, I want to make sure I've. . . .

A Okay.

Q . . . . covered what would cause that, and that would be – one is the uterus doesn't constrict?

A Uterus doesn't constrict and you have this whole – it's like hamburger meat on the inside – a whole muscle of raw, irritated – it's been surgically scraped, and so it's oozing, and if the uterus doesn't contract and cause the pressure to cause these veins on the inside of the uterus to clot off, they will ooze blood, or if the uterus is perforated and you have a vein on the outside of the uterus, on the wall of the uterus, and that can bleed internally to intra-abdominal. So that's why you can have both bleeding that

goes internal intra-abdominal or external, from the inside of the uterus that goes down the vaginal vault externally.

Q And what about an incomplete abortion?

A Incomplete abortion is you have retained placental parts. They keep the uterus from contracting, and so that bleeding is generally going to be external as the infection – once the uterus doesn't contract, you're going to have a higher likelihood of bacteria migrating up the vaginal vault into the uterus itself.

Q All right. I didn't ask you this earlier, but can you kind of give me the order of magnitude in terms of all the abortion complications you've described, of which ones you see that are more prevalent, less prevalent?

A The most common one would be your psychiatric, your depression, the guilt issue, and kids who handle that with inappropriate – I mean, if they're by themselves the suicidal ideation, suicidal attempt, that's your most common. Your next common as far as – would be infection, this intrauterine that has not gone bloodstream, that's from an external focus rather than a ruptured uterus, and then bleeding, which is external, and the bleeding sometimes just requires uterine massage or repeat D & C, but the bleeding is probably the least common of those three. Now, perforation of the uterus as a cause of those is less common than any of the others, and then sterility is an issue that we see later, but that's your 10-year later when a woman wants to get pregnant. That's not something you pick up short term.

* * *

Q Dr. Anderson, when we broke we were talking about abortion complications and you were describing to

us what they were, and then particularly we were talking about how delay in seeking care for a complication might impact a young girl's health, and you told us about bleeding, and I don't want to go back to that. Let's talk about infection. How long – how much of a delay does it take for an infection to spread before something becomes serious?

A It is proportionate to the amount of bacteria introduced to a closed space, so you can't say that any infection is going to start off at the same level of severity, but once you have initis of infection where you have a locus of bacteria that have replicated enough to establish an area of infection, I would say in that environment four to 12 hours it's going to make significant difference, just the migration up the uterus into the fallopian tubes then makes the woman much more susceptible to tubal scarring and long-term infertility, and then the next step is at the fallopian tubes into the intra-abdominal cavity and seeding the bloodstream and intra-abdominal cavity. So four to 12 hours can be very significant time delay once initis of infection is established.

Q All right, let's talk about the – maybe we didn't talk about uterine infection. Let's talk about – uterine perforation, excuse me. Tell us about that in terms of the timeliness and the delay and what the impact is.

A Well, the uterine perf – perforation is much – if – if you hit the colon and that whole organ hadn't been sterilized in preparation for the abortion, it just has a huge bacteria count that's introduced into the abdominal cavity, so colon perforation – uterine perforation with colon perforation is very significant as far as a quick infection spread. I mean, four, six, eight hours. The – if the uterus is perforated and there's no colon violation, then it's slower

because the bacteria will probably come up from the vaginal vault into the uterus, and then – we're just not talking about as a short of time period as the colon perforation would involve.

Q What is the time frame we're talking about?

A Probably eight – eight to 10, 12 hours.

Q Okay. Just focusing on uterine perforation, you seem to be describing, like, the negative consequences of that being infection and/or bleeding. Is there something independent of those that – that it's a problem with a uterine perforation, or is that pretty much it?

A That's pretty much it. I mean, if – if you have uterine perforation sometimes the only way you can stop it is to do a hysterotomy, and then you're going to have infertility along with infection and bleeding because she's lost her ability to – to get pregnant. If – if the colon's perforated, then you're going to have a colostomy, and what that would entail, and, thankfully, they're not that common as far as uterine/colon perforations, but it – it opens up that whole arena of complications if you have a colostomy.

Q Okay. Let's focus on the individual abortion complications, and I want you to talk to me about what the symptoms are for recognizing that that might [sic] a problem. If we have an infection, what are the symptoms that a young girl or a parent might be looking to recognize to figure out that there's an infection relative to an abortion?

A Pain, bleeding and fever, and generally you'll have – and what's difficult to recognize that is that after an abortion a young lady is definitely told you will have some pain and you will have some bleeding.

Q And how do you know that?

A Well, because all of our ladies that we do uterine biopsies looking for uterine cancer, anything like that, whenever you violate the cervix and do a procedure on it and then you have uterine contraction, you will have pain, and so that's the common instructions that I've seen on postabortion instruction lists, as well as what we tell our ladies. Now, we don't do abortions, but we might do a biopsy of the uterine lining, and we tell them you will have some pain and some bleeding. Now, for a young lady, a young girl who's wanting this process to end and denial is playing a significant part, hoping that this is just all normal process of finishing it, she's not going to look at escalating pain as necessarily an abnormality. That's what the doctor told me, and, therefore, it's not going to be a red flag to her, as is bleeding. He told me I was going to have some bleeding or she told me I was going to have some bleeding. And so the symptoms aren't some obscure things. It's common. It's just the degree of the symptoms that alerts us that we're not heading in the right digr – direction.

Q And the symptoms that you've described, are those the same symptoms you would see regarding infection, bleeding, uterine perforation; pain, bleeding and fever, are those the same symptoms you see for all those. . . .

A Well. . . .

Q . . . . or are there more?

A Well, the fever is kind of the last thing that happens with infection. I mean, you have pain, you have bleeding, you have fever, and then an escalation of pain,

escalated bleeding and escalation of fever, but as – as the infection gets established and – you'll have the fever, and if the young lady – young girl isn't taking her temperature, she just might notice it as chills and feeling hot. Now, if it's purely bleeding they won't have fever. I mean, if – if you just have the uterus not clamping down, you could have not much pain, but significant bleeding only, no fever with that, but with infection you generally have fever, bleeding and pain.

Q Now, is the bleeding always externally visible?

A No. If – if there's uterine perforation and the venous structure of the uterus is – there's some large veins on the outside of the uterus, and if one of those veins is lacerated, you'll have leakage of blood into the intra-abdominal cavity and she won't know that.

Q All right. What has been your experience as to the ability of young girls 16 and under to recognize these symptoms and put it together that they need to come to a physician for help?

A It's very compromised, because they're dealing with denial, they're dealing with symptoms that they've been told will occur, and that combination means they'll sit tight. I don't want anybody to know what's going on, I just want to get it over, and the doctor said these are going to happen, and so their ability to act appropriately is very much compromised or delayed.

Q In those cases of abortion complications that you treated where the young girl had not informed her parents previously of the abortion, how prevalent has been the delay that you've seen?

A It's generally that six to 12 hours, the delay. It's significant.

Q But in how many of the cases?

A Oh, I would say of that subpopulation of 10 to 20 girls that I see a year it's 80 to 90 percent of them, because their parents weren't involved. I mean, this high-risk behavior does not involve their parents.

Q And when. . . .

A So. . . .

Q . . . . there has been parental involvement, how has that been different?

A They've come earlier. They come at the beginning, and they're not near as sick. We do have some parents who will know that their children are sexually active and want them on contraceptives, and the pregnancy will happen, so they're involved in that whole process at an earlier stage.

Q All right. Do you have an opinion, Doctor, regarding the value of parental involvement in a young girl's postabortion care?

A I think it's critical.

Q Why?

A Because we institute timely care and cut down complications and the severity of the complications with the timely care.

Q Have you in your experience seen young girls who have presented for an abortion complication at your ER with her parents, and her parents were in your observation, in your opinion, loving and caring parents, and yet,

nonetheless, the girl had not told her parents of a pregnancy or abortion beforehand?

A Yes. I mean, as a particular – some – say a pastor and his spouse, and the daughter knows they're loved, they know that the home is a very relationship-oriented home. . . .

Q Is this an actual experience you're relating. . . .

A Uh-huh.

Q . . . . to us?

A Yes.

Q Go ahead and tell us about it.

A And the daughter knows she's loved, but she also knows this could be very much of an embarrassment to her father or mother in their role as a pastor, and say out of deference to them she will want to have this hidden, and it's not because she is afraid that they're going to abuse her. And then there's another situation where I've seen where a single parent might have two or three kids and their single mother's have just done a tremendous job in picking up the ball, where a lot of dads hadn't stayed around, and that teenager who's helped could end up pregnant, and they say, man, this is going to be a stressor on Mom, Mom might not be able to afford it, we might not have insurance, Mom doesn't have the time for this, and they just really – they're in a very functional loving relationship with their mom or dad, if he's a single parent, but they don't want to add another stressor [sic] the home environment, so they will go out and try to hide it [sic] that situation, so. . . .

Q Have you had young girls actually relate these things to you?

A Yes. Yes.

Q And – I interrupted you, I'm sorry.

A So I would say young ladies – young girls from relationship-oriented families trying to avoid the embarrassment of the family or trying to avoid disappointing parents that they love or trying not to add another stressor to the situation are all very much players in that decision tree of the young girl.

Q Have you had an opportunity to learn the age of the males who typically have impregnated adolescent girls 16 and under who present for either pregnancy or abortion complications in your ER?

A That hadn't been something that I'd say I have a grasp on from my experience.

Q Well, let – let's not go there, then. Okay. Have you had an occasion for young girls to relate to you when they come to your ER for an abortion complication why they came to the ER, as opposed to going back to the abortion doctor?

A Well, they – they perceived – they didn't like being there to start with, this – this whole process of being pregnant and then trying to hide it is not something that they're excited about or enthralled with, but I've had young ladies say the doctor didn't spend any time with me or the doctor didn't care, or the doctor didn't use gloves, or the doctor just treated me with such rudeness, and they didn't – there wasn't something there that attracted them to want to go back. There wasn't anything there relationship-wise

or connectedness-wise that made them want to go back, so they've come to the emergency room.

Q Have you in your career ever seen a woman present at your ER – not just adolescents, any woman – for an abortion-related complication related to a self-induced abortion?

A No.

Q Have you ever in your career seen a woman present at the ER with a complication related to an illegal abortion?

A No. I mean, my – my career has been since abortions have been legalized, I mean, so I've never seen – I mean, I started practicing medicine in '78. . . .

Q I suppose an illegal abortion might be one performed by somebody other than a physician.

A Yeah. I – I – I don't think I've ever had that happen.

TESTIMONY OF DR. FIGLEY

Q Dr. Figley, what types of stress, if you – could you tell us what – the general types of stress that occur in people's lives?

A Typically there are two, normative and catastrophic or traumatic.

Q Okay. Could you give us a couple of examples of normative stress?

A Normative stress is the stress that my family's going through now in anticipation of our youngest daughter leaving home and going to college, normal childbirth, entering and exiting of the family are quite normal, buying a new home, et cetera. And traumatic is a – an untimely death in the family when – anytime a child dies is certainly a traumatic event. A natural disaster, the – the kinds of disasters that have happened here in – in – in Alaska with regard to earthquakes are examples.

Q Doctor, what factors influence the severity and the intensity of traumatic stress for an individual?

A Among other things, it's associated with the amount of support, the degree of timing in terms of how old the person is, their degree of exposure to similar kinds of traumatic events, their self-awareness of their ability to survive and thrive under various kinds of circumstances, but much of it is really associated with social support, be able to provide an – an opportunity for the individual to process and work through the experience.

Q What does social support do for a person faced with traumatic stress?

A It enables the person to see things in a broader perspective, to be able to be in touch with their own natural coping abilities. It provides an opportunity to talk through and – and verbalize the anxiety that they feel. It enables them to receive solace and emotional support and love and caring in a time that they really need that.

Q Doctor, what's the normal social support for a minor who's faced with traumatic stress?

A The normal support of a minor is – are her – his or her friends, but especially her family, and lots of research

on social support, even through college students that are seniors, they identify their parents as the primary source of support.

Q Okay. As a social support resource, what does the family have going for it regarding giving social support to a minor?

A Mostly knowledge of that child. They're familiar with the various kinds of personality differences, the various kinds of – of ways in which they've coped in different kinds of circumstances, they can remind them of who they are, they can talk about the parents' experiences at that age. So it provides a broader perspective for them.

Q Do families in your opinion tend to stick with a child in – faced with traumatic stress regardless of the circumstances?

A Yes, they stick with the child no matter what the circumstances are. Even though they may initially be shocked and – and disappointed, they will come around, because there is a lifelong commitment long after the crisis is over.

Q Okay. Dr. Figley, in your opinion is an unexpected or unplanned pregnancy to a minor a traumatic event?

A Yes.

Q And is that a traumatic event to her family as well?

A Absolutely, yes.

Q Can catastrophic or traumatic stress influence a minor's decision-making ability? And let me qualify when I say minor. We may have been assuming just because we've

talked before, but just for the record I'm talking about girls 16 or younger in this context, okay?

A Yes, without a doubt. I mean, when you're exposed to a traumatic event, by definition it's extraordinary, unusual and leads to a sense of crisis and disbelief and panic, and, therefore, it's critically important for the parent and those who love and care for her to be around her and to provide that kind of support and perspective.

Q Doctor, getting back to our statute, in your opinion would most unemancipated minors benefit from the Alaska statute requiring parental consent for a minor's abortion?

A Yes.

Q And could you tell us a few reasons why you believe that?

A Primarily because they – it will encourage them, indeed, it will prevent avoiding exposing the parents to this reality. It will enable the parents to be able to support the child, to be familiar with her mental, as well as medical needs. It will help her in seeing all the various kind of alternatives, including abortion, and it will – among other things, there will be an opportunity to express their love and concern and – and – and support for her.

Q Doctor, are you aware of studies showing that when parents learn of an unplanned abortion for a minor child that they tend to actually support an abortion decision?

A Yes.

Q And what benefit can that bring to the minor if the parents are supportive of that?

A It will support them, among other things, for the rest of their life. As they, as all of us do, begin to think about the decisions they've made in their life and perhaps regret those decisions, they will feel a tremendous amount of support knowing that it wasn't just their decision they did alone, but – but, rather, a – a – a decision that was done with considerable thought and – and with the support of one's family.

Q Doctor, then you believe it would help in the way that a minor would not be taking the whole responsibility on herself for this decision, but would be sharing it with her family.

A That's right.

Q Doctor, you – have you had considerable experience, including clinical experience, with dealing with intrafamily violence?

A Yes.

Q And if we have a minor from a family that's experiencing intrafamily violence, what do you see their options would be under the parental consent act we're talking about?

A It's my understanding that there is – is the probability – not the possibility, the probability – of judicial bypass.

Q Doctor, are you aware of any research right now at this point showing that there are many minors who

actually suffer violence because of informing a parent of their unplanned pregnancy?

A No.

TESTIMONY OF MS. COLLETT

Q We were talking about your research regarding pregnancy and abortion rates in Texas after January 1 of 2000.

A Yes.

Q Can you tell us what you've done and what you found?

A One of the questions we had was what would be the effect of the parental notification law, if any, on Texas pregnancy and abortion rates, and whether there would be any effect, and so we looked to see what the Texas Department of Health showed, and as the expert witness report tells you, there are a couple of – of ways to – to measure that. One of the – the things that we learned is that there was a five-percent drop in '99 – from '99 to 2000 in Texas minors' pregnancies, from 26,117 to 24,665 pregnancies. Mothers age 10 to 17 accounted for 5.7 percent of births in 2000, compared to 6.1 percent in 1990. During that same year induced abortions performed on minors declined approximately 20 percent, from 4,798 in 1999 to 3,830 in 2000. This decline is substantially higher than an overall decline. We saw a decline in abortion in Texas throughout, which was a 5.4 decline in abortion on all Texas residents during 2000. I was interested to see if we saw that same sort of dramatic decline in this past year. Those were only recently posted to the Texas Department of

Health website. And the – the easier tables to look at are the table 14B, and those are perhaps the documents that you hold in your hand.

Q Yeah, I – perhaps at this point I could ask you to take a look at what's been marked as Defendant's 2273, and I have a copy for the Court.

THE COURT: Is this the new one?

MR. CLARKSON: This is the new one.

THE COURT: All right.

Q Can you tell the Court what that is?

A These are the recently-posted statistics on 2001 pregnancy/abortion statistics for the state of Texas.

Q When you say new, what does that mean?

A Well, compilation of all pregnancies, whether they were brought to term, whether they resulted in induced abortion by county, fetal deaths, et cetera.

Q When did this information first become available to you for review?

A The – this is printed from the website, and the – at the bottom of the page gives you when they were posted on – for example – oh, I beg your pardon. One of the tables was available December 16th, so. . . .

Q All right. And how does this information relate to the research and study you've done on pregnancy and abortion rates in Texas?

A Well, to the extent that there is a substantial decline in abortions and pregnancy, I wanted to see if it

was a continuing trend and – or whether it was a one-year decline, and – and what we see is in 2001 we see a continuing decline in pregnancy and a continuing decline in – in the – the number of abortions, but the decline in the number of abortions is not nearly as – as dramatic among teenagers. On table 14B, which is. . . .

Q What page. . . .

A . . . . the. . . .

Q . . . . are we on? What page are. . . .

A Table – let's see. If you turn to – let's see. It would be the one that says pages 1 of 8, about six pages in.

Q All right. It says preliminary Texas Department. . . .

A Yes.

Q . . . . of Health? Okay.

A This is women's ages 13 through 17, Texas 2001. This document doesn't include – this was last updated on December 17th of '02. It shows us that total pregnancy among women in Texas ages 13 to 17 were 23,416. That's a total decrease from 2000 of 1249, a five-percent decline in pregnancy over 2000. Still, a nice decline. And abortions continue to decline 3,555, a total decrease of two thou – of 247 or a decrease in abortion of six percent. Not that big decline we saw in the year 2000.

* * *

Q Now, have you had an opportunity to study and research voluntary parental involvement of young girls in their abortion decisions?

A Yes.

Q And what have you found in that regard?

A During our hearing when we were passing the – the act the Texas Family Planning Association presented a voluntary study of various Planned Parenthood organizations that showed 69 percent of minors in Texas involved a parent prior to obtaining an abortion.

Q All right. What do studies show regarding the reasons most young girls choose not to involve their parents in their abortion decision?

A The majority of girls are afraid of disappointing their parents.

Q What did, specifically, information reveal regarding voluntary parental involvement in Texas prior to the enforcement of the parental involvement law there?

A Again, while it varied from city to city, it – it showed that approximately 69 percent, which is higher than most of the published studies, but 69 percent after passage of parental notification. If the study from the payment of legal counsel and guardian ad litems reflects the number of bypasses, then we had a 95 percent parental involvement rate, so we increased our parental involvement significantly by the passing of our parental notification law.

Q Do you have an opinion as to whether or not that is a benefit to young girls pursuing an abortion decision in Texas?

A Absolutely. It certainly ensures that you have an adult that can assist them if there are any postoperative problems.

MS. CREPPS: Your Honor, I'm going to object to the witness getting into whether adults can assist and what rate. I think this has been excluded testimony.

THE COURT: Mr. Clarkson, would you like to move on?

MR. CLARKSON: I can move on.

THE COURT: All right.

Q Do you know of any cases in Texas, Professor Collett, where a young girl's abortion decision has been substantially or significantly delayed because of the parental involvement law, or the bypass, in particular?

A Not that I'm aware of.

Q Based upon your research and study of this issue, and based upon your experience with the Texas bypass process, do you have an opinion regarding whether mandatory parental involvement laws are important?

A Yes. As a matter of fact, they are. Appearing to be increasingly important in helping parents recognize the effect of adult men's involvement with their minor daughters.

Q All right. Let's move to another issue at this point and talk about have you had the opportunity to review and study the ages of the males who impregnate young girls, typically?

A There was a study in California by Mike Males that showed that two-thirds of all adolescent pregnancies were by men that were post-high school age, 20 or older. There's the study of journal – the Journal of Adolescent Health that indicates that two-thirds of all Alaska pregnancies under the age of 16 are the result of statutory rape, and in Texas we are concerned that, in fact, we have a similar problem, and that was one of the motivating factors of passing this particular law. . . .

Q Okay, let's. . . .

A . . . . as a matter of fact.

* * *

Q All right. What I was asking you was for your experience with parental involvement laws have you learned informed regarding the sexual exploitation of minors by older males, and I'm focusing on your Texas experience at this point in time.

A Yes.

Q And tell us what you've learned in that respect and how you learned it.

A We learned that there was a concern both in the committee, because as judges examine the – the girls and ask about the age of the partner about whether they're – they're being coerced into having an abortion, judges were concerned about the reporting duty. There was discussion about how judges were to handle that. There's a concern about we – we've also – I've also learned about it through press reports. As mentioned in my expert witness report the – the Planned Parenthood. . . .

* * *

Q Professor Collett, do you have any opinion based upon your experience, research and study regarding whether participation in judicial bypass proceedings benefits young girls who are contemplating the decision of abortion?

A Yes, I do.

Q And what is that opinion?

A I believe that, in fact, a bypass proceeding can benefit a minor in that allows her the opportunity to have an adult who is not involved in the process of, if you will, encouraging her to obtain an abortion, in evaluating her decision. If she's not going to have the benefit of a parent in guiding her through the decision-making process the judge can at least have the opportunity to help her evaluate her three options, the option of carrying the pregnancy to term and keeping the child, the option of carrying the pregnancy to term and giving the child up for adoption, or the option of terminating the pregnancy, and ensuring that she's thought through these options carefully and maturely, or in the event that she's not sufficiently mature and well informed, can ensure that not involving a parent is in her best interest and that terminating the pregnancy is in her best interest. The other thing that's important to recognize is that for the minor that's not sufficiently mature and well informed and is the victim of sexual or physical or emotional abuse, the idea of simply giving this minor an abortion and sending her back into a home where physical or sexual abuse is going on is not the right answer. It's very similar to situations that – that are tragically occurring, where the girl is given the abortion and sent back into the house to be abused again.

MS. CREPPS: Your Honor, I'm going to object because I think any opinions that she has on that particular topic are probably based on newspaper articles and. . . .

THE COURT: I'm going to sustain it. Lay a foundation for that part of the opinion.

Q Let's do this. Now, I want to ask you to assume that Judge Martin has testified in this case that in his view bypass proceedings have no purpose or value. Do you have a response to that?

A I think bypass hearings where a judge does not take the time to explore with the minor the basis for her decision and evaluate the various the options she has can have no value or meaning, but where a judge, in fact, informs himself of the options that the girl has before her and carefully explores with the girl the reasons that she chooses one option among the three options that she has, and explores with her the reason that she's choosing not to involve the parent, can be a very helpful process if she is sufficiently mature in confirming that choice, and if, in fact, she's not sufficiently mature, can protect her against the harm that she can suffer by impulsively choosing something that's wrong for her.

Q I want you to assume that Judge Martin has testified to the effect that the largest percentage of girls who pursued bypass in Minnesota complain of dysfunctional family situations. Do you have a response to that?

A In Texas, again, the primary basis for the application is that the minor is sufficiently mature and well informed.

TESTIMONY OF MR. ZIELINSKI

Q During the months of February and March 2002 did you participate in the conducting of a telephone survey for Life Dynamics?

A Yes, I did.

Q What was this telephone survey that was conducted?

A It was a survey of abortion providers across the United States, primarily those affiliated with Planned Parenthood and the National Abortion Federation.

Q What was your role in conducting this telephone survey?

A I monitored the conversation by listening to both sides of the conversation and tape-recording the conversations.

Q Who else participated in this telephone survey with you at Life Dynamics?

A We hired a girl who has the voice of a very young girl, and she was the caller in these.

Q And what was the relationship of the female caller to Life Dynamics?

A She was an employee.

Q What was the age of the female caller in reality?

A Twenty-four.

Q And how did the female caller identify herself when the telephone calls were made in the telephone survey?

A She identified herself as a 13-year-old, soon to be 14 years of age, who was involved with a 22-year-old man.

Q Anything else?

A I'm sorry?

Q Anything else?

A And she explained that she did not want her parents to know about the relationship, that she thought that she was pregnant, and in the course of that she was asking about abortion services, birth control provision.

TESTIMONY OF DR. ZABIN

Q All right. And the reason that teens have a tendency to engage in unprotected sex and to not think about protecting themselves with contraception is they simply don't know how to negotiate the health system in order to get the help they need.

A That's one of many reasons.

Q And the reason teens have a lack of ability to negotiate the health system is that they've never done it before?

A Very often that may be the case.

Q They lack the particular life experience associated with doing that?

A That is also possible.

Q You agree that it's true, don't you?

A Yes. I just want to make clear that none of these reasons are exclusive, that. . . .

Q Did you. . . .

A . . . . they are part of a large list of reasons. . . .

Q All right.

A . . . . yes.

Q But you agree with me that those are reasons.

A Oh, those are certainly included in the list.

* * *

Q Dr. Zabin, are you telling me you think young adolescents in Alaska are going to be aware of the state of the law regarding parental involvement and notification – consent in Alaska, and modify their behavior based upon that knowledge?

A Some adolescents.

Q You think it's possible some adolescents will do that?

A That they would change their behavior because of it?

Q Based on their knowledge that the law existed or didn't exist. . . .

A I would hope. . . .

Q . . . . whatever it is about. . . .

A I would assume that some would present at a clinic for some services if their knowledge was correct, rather than incorrect, yes.

Q Now, delaying decisions based upon misperceptions and misunderstandings, that is typical of adolescent decision making, is it not?

A Excuse me, delaying it based on. . . .

Q Misperceptions or misunderstandings. That's typical of adolescent. . . .

A That is one. . . .

Q . . . . decision making.

A . . . . of the reasons for delay.

Q It's typical of adolescent decision making.

A Misperceptions are typical of many ages, certainly of adolescents as well.

Q All right, so you agree it's typical of adolescents as well.

A Typical of adolescents as well, yes.

Q Dr. Zabin, you don't believe that public policy and law should be determined based upon the misperceptions of adolescents, do you?

A No, I do not.

Q Dr. Zabin, you agree, don't you, that the way in which a young girl will react to a situation and her mental/emotional ability to deal with a situation, one factor that affects that is her age?

A One factor, yes, but I do not believe that one can characterize the reaction by age.

Q Now, you've talked about how you think that adolescents, I guess in the United States, not just Alaska, have this concern that when they go to a health care provider their confidentiality is going to be breached.

A They appear – they tell us that that belief delays their attendance, yes.

* * *

Q Okay. Now, you told Ms. Novak that you thought in families where there are longstanding communication patterns parental involvement is a very positive thing for those young girls, correct?

A I'm afraid I have a basic prejudice in favor of intact families with good communication patterns. I – I certainly have in my research seen evidence that if those communications are to have an effect, they have to be longstanding, and what the girls and the mothers describe as easy.

Q All right, now, you told Ms. Novak that you thought one of the conclusions you could draw from your study, Exhibit 164, was that it could mean that parents, in fact, discourage abortion. Now, if you have girls in your study. . . .

A Now, it – I testified – I'm sorry, I – I'm not sure I testified to that effect. I remember testifying to the effect that it was quite possible that the parents might if forced into the discussion try to force abortion. Might, might not.

Q All right. Might attempt – let's ask it this way. If you have a family in which there's a longstanding communication pattern and the young girl talks to her parents,

and as a family they decide that the young girl will not have an abortion. . . .

A Uh-huh.

Q . . . . so it's a family decision in the context of a family

with a longstanding communication pattern, it's not a bad

thing, is it?

A No.

Q Family decisions for adolescents in which they have the support of quality parents is a positive thing, isn't it?

A Yes, in either direction.

TESTIMONY OF MS. FOSTER

Q In your experience as a prosecutor is this the usual situation, that parents are the ones who report these offenses of – offenses occurring to their daughter?

A To the extent that I'm aware of how law enforcement or social services becomes aware, the majority is parents reporting.

Q In your experience in this area is it common or rare for a girl to turn her boyfriend in, the adult boyfriend who is sexually abusing her?

A Rare.

Q Can the police use fetal tissues that would come from an abortion for DNA testing to identify who the father of the child is?

A Police can do that, yes.

Q And in your experience has that been done in the state – in Alaska in identifying sexual – sex offenders?

A I'm aware of cases where that's been done that I wasn't personally involved in, and cases that I have been involved in that's been an option to be considered.

Q Now, have you read the – Alaska's parental consent statute?

A Yes, I have.

Q Do you have an opinion on whether the Alaska parental consent statute would – whether or not it would increase the rate of reporting, by making parents aware of sexual abuse?

A I do.

Q Can you tell us what your opinion is?

A I believe that if parents were required to be notified and consent to an abortion, that that would increase the rate of reporting of cases in the category of sexual abuse of a minor in the second degree that you're discussing.

Q Do you have an opinion on whether or not the parental consent statute would help police in identifying offenders by the collection of fetal tissues from abortions with DNA testing?

A I'm sorry, I missed the first part of the question.

Q Would – do you have an opinion whether or not the parental consent statute would help the police to be able to identify the offender with the collection of fetal tissues from abortion for DNA testing?

A Yes, I do have an opinion.

Q And why do you think that would happen?

A I think it would increase it, and – and part of the reason is that the cases I'm thinking of in which they've considered getting fetal tissue from abortions is where the – the question of whether or not there's going to be an abortion is something that's not known for a certainty with the police, and so they're sort of watching the situation, hoping to be – to know about it in – in order to get the fetal tissue for testing. With the requirement for parental notification and involvement of parent in that, the likelihood would be increased that the law enforcement would be notified and be available to take the fetal tissue sample at the time of the abortion.

Q Do you have an opinion on whether or not the parental consent statute with [sic] help prevent sex offenders from coercing young girls to get abortions in order to hide their crimes? Do you have an opinion in that area?

A Yes.

Q And what is that opinion?

A To the extent that it would advise the parents that the child is sexually active and lead them to determine who the offender is and, based on my experience, put a stop to that, I believe it would have an impact on the amount of child sexual abuse that would be perpetrated after that point.

Q Do you have an opinion whether or not the parental consent statute would help law enforcement identify serial rapists and stop not only the continued sexual abuse of the girl who is impregnated, but other girls who as well could be victims of the offender?

A Yes.

Q And can you give us your opinion?

A My opinion is that it would have an effect on – it would have that effect of increasing the number of people who do this on a serial basis – it would have the effect of decreasing the number of people who have the opportunity to do this on a serial basis. My experience is that these – that often offenders who are targeting girls in this age group stay targeting girls in that age group until there's intervention of some kind.

TESTIMONY OF MS. SABINO

Q Ms. Sabino, the study that you talked about that you had conducted in Massachusetts. . . .

A Yes.

Q . . . . there was a quantitative portion and a qualitative portion to the study.

A That's correct.

Q In the quantitative portion of the study some 490 girls were interviewed by Planned Parenthood counselors when they first called the Planned Parenthood information hotline?

A We used the interviews that they conduct with young women who call the hotlines and took data from those. The interviews were not for the purpose of the study.

Q I understand, but the interviews occurred when the girls called the hotline.

A Correct.

Q All right, and there's about 490 girls?

A Correct.

Q And in the interviews the girls were asked questions such as why are you seeking not to tell your parents about your pregnancy or your abortion.

A Correct.

Q And in the qualitative study – smaller study, right?

A Correct.

Q There were about 26 girls who went through the bypass procedures that were personally interviewed, right?

A That's correct.

Q You didn't participate in those interviews.

A No, one of the other investigators.

Q And these girls were also asked how they would describe their relationships with their parents.

A That's correct.

Q And why they didn't want to tell their parents about their abortion decision or their pregnancy, right?

A Right.

Q Ms. Sabino, you're an activist against parental involvement laws across the country, are you not?

A Yes, I am.

Q Because you've gone to a number of states you've told the judge about previously. You've testified in legislatures, courts. Every time you do this you're against a parental involvement law.

A Yes.

* * *

Q All right, Ms. Sabino, in the qualitative study you conducted in Massachusetts 73 percent of the girls interviewed live with at least one of their parents.

A Yes, I believe that's correct.

Q And in the qualitative study one-half of the girls reported that they had position [sic] relationships with their parents.

A Yes.

Q Yet despite these positive relationships with their parents, these girls were, nonetheless, seeking to bypass their parents and obtain an abortion.

A That's correct.

Q So we know that at least half of the girls in the study were pursuing a bypass, trying to avoid parental

involvement, despite the fact of having very positive relationships with their parents.

A Yes, because many of them did not want to harm those par – positive relationships.

Q Right, and so the point. . . .

A Right.

Q . . . . that I'm making, and I think you're agreeing with me, is that most of the girls who sought bypass in your study had positive relations with their parents, but, nonetheless, tried to exclude their parents from the bypass and – the abortion and the pregnancy issue.

A In the 26 minors that had the qualitative interview, yes.

* * *

Q Ms. Sabino, in your study isn't it true that you found that 27.4 percent of the girls – I'm looking at page 43 of your study – when asked why they felt they could not tell their parents about the pregnancy indicated the parents would be extremely upset or upset?

A Yes.

Q Now, there was absolutely nothing in the answers that they were giving at that point that indicated that had anything to do with abuse or fear of abuse.

A Correct.

Q All right. And you indicated that a total of 22.4 percent said that they did not want to damage the relationship they had with their parents.

A That's. . . .

Q These. . . .

A . . . . correct.

Q These minors expressed concerns such as that their parents would lose trust in them, be profoundly disappointed because of high expectations, or no longer respect them.

A That's correct.

Q And, again, that had nothing to do with some sort of a dysfunctional abusive family. It just had to do with not wanting to disappoint the parents or lose trust of their parents.

A Right, that particular question did.

Q That's what I'm talking about.

A Right. I'm saying some minors gave more – a number of them gave more than one reason, but that particular codification was not. . . .

Q We're just taking them one at a time here.

A Right.

Q 22.2 percent gave a reason associated with their parents' ideological stances about abortion, pregnancy and with childbearing.

A That's correct.

Q Right. And that again has nothing to do with a dysfunctional family per se or abuse. It just has to do with parents having views about issues that children may not agree with.

A Right, but I – I guess – may – may I clarify? You're saying that the minor who said that did not fear abuse; is that the point you're making?

Q I'm saying your report reflected. . . .

A Because some of those minors may have also given the same answer about abuse.

Q Right.

A Particular minors gave – gave more than one answer.

Q And if we turn to page 44. . . .

A Right.

Q . . . . of your report, what you found was that 18.8 percent referenced some sort of an abusive situation.

MS. NOVAK: Your Honor, I'm going to ask if counsel's going to ask her to refer to specific tables and percentages that he offer to show the tables to the witness.

MR. CLARKSON: She seems to be answering per – fine. I guess. . . .

THE COURT: Do you need to see a copy of this?

A At this point I don't because I recall. . . .

THE COURT: All right.

A . . . . I recall generally. . . .

THE COURT: You recall. That's fine.

A . . . . those statistics. . . .

THE COURT: Okay.

A . . . . and I'm assuming you're reading the numbers that are on the page.

Q It was 18.8, only, that had been referencing some sort of an abusive situation.

A Yeah, I think – I think the words we use were ad – concerned with severe adverse consequences.

Q Severe adverse reaction?

A With severe – yes.

Q And, in fact, that's not even limited to abuse, is it? That's just a severe adverse reaction that could be something other than abuse.

A It invol – it was physical abuse, throwing them out of the house, emotional – severe emotional abuse.

Q Right, and the number of girls who said they feared physical harm was three?

A Yes.

Q And that's the quantitative study.

A That's the quantitative study, yes.

Q All right, now, if we go to the qualitative study, which is the interview with the 26 girls?

A Yes.

Q And looking at page 92 of the exhibit, 13 or half of the girls in the sample reported having a close or good relationship with one or both parents.

A That's correct.

* * *

Q Now, if a parent has a view, moral or religious, about abortion, you would agree with me, wouldn't you, there's absolutely nothing wrong with that parent talking to their child about that view?

A Correct.

Q It's a good thing when parents and children talk, right?

A Usually. Not always.

Q If they talk in a good family relationship, they have good communication, whether the parent is relating a religious view or a moral view about something, including abortion, it's not a bad thing.

A It depends on what the parent says, so I can't say whether it's a good thing or a bad thing.

Q Let's assume it's just a nice conversation. They're talking about the parents moral view of abortion or religious view of abortion.

A Can I repeat again, it depending – it would depend on what words the parents use. In most cases it would be fine. In some cases it could be very harmful.

* * *

Q Now, two-thirds to 75 percent of the girls in Massachusetts who get abortions do so with parental consent, don't they?

A I – yes. Those are roughly the figures.

Q All right. In fact, about 10 percent of the girls who go through bypass in Massachusetts have notified their

parents and the parents have refused to consent for abortions; that's the percentage in that respect.

A Approximately. We don't have a specific, but approximately.

Q It's a very small percentage.

A Correct.

Q Now, you told us earlier that the number of bypasses that are happening in Massachusetts now are about four. . . .

A Four-fifty to 500.

Q I thought I heard you say 400 to 450.

A I – I thought I said 450 to 500. . . .

Q I. . . .

A . . . . but I'm not sure.

Q Actually, you're correct, it was four – I wrote down 450 to 500. So if the rate of bypass is – now is 450 to 500, you testified in Florida in 1999 that the rate of bypasses was 550 to 500; is that correct?

A That's correct.

Q That was in 1999?

A That's correct.

Q And in the New England Law Journal, the article you wrote. . . .

A Right.

Q . . . . in 1991?

A '91, yes.

Q You said that the rate of bypasses at that time was about 900 to 1,000.

A That's correct.

Q So the rate of bypasses in Massachusetts has been steadily declining over time.

A That's correct.

* * *

Q Now, in Massachusetts from the '80s to the '90s the numbers of young girls giving birth in Massachusetts dropped, did it not?

A That's correct.

Q In other words, the teen birthrate went down.

A Yes, it did, as it did nationally.

Q And during the same time period the teen abortion rate in Massachusetts went down?

A I believe it did. You have to think about the number of young women who go out of state, because the Massachusetts abortion rate only reflects what you get from the department of public health those young women who had their abortions in Massachusetts. The teen pregnancy rate also only reflects those young women who had abortions and births in Massachusetts, so neither of them take into account young women who went out of state. However, nationally teen pregnancy, births and abortions did drop, and my understanding is that in Massachusetts the drop – the estimated drop is in line with the national trends.

APPENDIX B

DEPOSITION TRANSCRIPT SELECTIONS FROM *PLANNED PARENTHOOD OF ALASKA V. STATE* IN THE SUPERIOR COURT OF ALASKA, 2003, CASE NO. 3AN-97-6014 CIV.

TESTIMONY OF DR. BRIND

Q: Doctor, having reviewed this and looked at this study and from your own med analysis experience, was Dr. Daling's study, a methodologically sound one?

A: Yes, very much.

Q: What were the findings of her study about the increased risk, if any, of breast cancer for women who had induced abortions?

A: They found that overall women who had had an abortion were 50 percent more likely to have been diagnosed with breast cancer which would be a relative risk of 1.5. That's what they reported.

And in addition, they found that in certain subgroups of women, in particular women who had an abortion before the age of 18 or women who had an abortion over the age of 30, the relative risk was greater than two. So there was about over 100 percent increased risk for those women.

And for those women who had family history of breast cancer, so that is women who had a family history of breast cancer and a history of abortion, compared to women with a family history of breast cancer and no abortion, the overall increase was 80 percent rather than 40 percent in women who didn't have family history.

When they looked at women who had a family history of breast cancer and who had an abortion over the age of

30, there was 270 percent increase in the risk of breast cancer. And for women had an abortion before the age of 18 and who had a positive family history of breast cancer, they reported the statistic relative risk equals infinity because the only women who fit that reproductive history were women who were in the cancer group. There were no women who did not have cancer in their study population that fit that category.

Q: How many –

A: That was a total of 12 women.

Q: So 12. And all 12 of them in the study had breast cancer?

A: Yes.

TESTIMONY OF DR. ADLER

Q Regarding your studies, in contrast, early adolescents deal with both pregnancy and its termination by using denial.

Do you still think that's the situation?

A I think younger adolescents may tend to use avoidance as a strategy, avoidance and denial, more frequently. We don't have really strong data on that, but my guess is that may be true.

Q And you state that regarding middle adolescents – that's what we're talking about, 15, 16-year-olds, right?

A Right.

Q – were less able than older patients to anticipate their reactions. They experienced more post-abortion depression than they had expected.

A This was I think the study based on – was it the Hatcher study? – which was a very small number. And in larger samples and more representative samples, that hasn't been shown to be the case. Now, it may be that –

* * *

Q In your original draft report or your article, I was reading in your Florida testimony there was data regarding higher avoidance in the under-age-18 group. Was that finally included in your final draft?

A No.

Q And why didn't you include that, that showed a difference in avoidance in the under-age-18 group?

A Because the measure that we were interested in was a stress response, and the particular measure we used had two sub-scales: one is intrusion, which is intrusive thoughts after a stressful event. Intrusive thoughts are when you think about it and you don't mean to. Avoidance is choosing not to think about it. Avoidance is a more confounded variable, because there's also an avoidant coping style. And it may have been related to why they got pregnant in the first place.

So we consulted with the author of the scale that measured this and asked, Is it better to use both, or is intrusion a purer measure of stress response?

And he said that if you really want a pure measure of stress response, the intrusion measure is the better measure.

When you write something up for scientific publication, there is a premium on brevity because journal pages are valuable. So to have first included the data on avoidance and then explain why we think it wasn't necessarily a stress response but related to avoidant coping style would have taken too many pages to explain, so we took it out.

Q But wasn't your finding consistent with other sudies [sic] which show that minors have a greater tendency to engage in avoidance.

A Yes.

TESTIMONY OF DR. GREENE

Q. In this area of keeping a secret, secret abortion, how does that interplay with the child relationship with her family?

A. Well, in my experience keeping a secret from your family about a major life event or any kind of thing at the level of having an abortion would have to – if I were trying to keep that from my family, or if a teenager were, I take – I strike [sic] that if I were, if a teenager were trying to keep that from their family, they would be on guard more commonly, I would think, they would be suspicious of things the parents did ask, were they going to be discovered, and so I think it would cause a – an alteration of the family's relationships and relate – and their relating to one another.

* * *

Q. In an article which you published yourself listed in your CV, "Teen Pregnancy, New Initiatives for an Old

Problem", in this article did you cite concerns regarding increased risk for girls under the age of 16 – under – under the age of 16 regarding risks of trauma to the cervix caused by abortions?

A. Yes. Any procedure to an immature cervix, and a – again a – normally an 11- to 16-year-old cervix is not fully matured. So any kind of trauma or injury to the cervix would be more significant in someone that age.

* * *

Q. Regarding your experience working at Planned Parenthood clinics as you've indicated in your prior testimony, did you notice any difference in the way the doctors treated their parents, the abortion doctors, in their physician-patient relationship as compared to with what would be the relationship that you would usually – that you would have?

A. I think the difference in a clinic setting in which the physician is not the primary care provider who might have a long-term relationship with a young person is primarily related to their ability to relate to one another. In other words, if I have an adolescent for whom I provided care who has developed some degree of trust in me, they're much more likely to share information as well as to let me know when there's a problem as compared to the person who may see a young person only once, perhaps for a procedure that limits the amount of time and the – and the degree to which a relationship could develop. So, knowing the young person, knowing the medical history, and their other needs is important. And – and – and many times time is the only way you can do that and spend time with the young person.

Q. Based upon your observations of the Planned Parenthood clinic, did you have any concerns of the way the doctors – they're providing adequate postoperative care without parental involvement to these children they provided abortions to?

A. Just that it's – it's generally an issue. I – I – my impression again is that if I am doing or a person – a physician is doing a one-time procedure and may never see that young person again, then that's very different that [sic] a physician who's doing a procedure, caring for someone who will see them back, make sure they're doing fine and has a long-term relationship with them.

Q. Based upon your experiences working at the Planned Parenthood abortion clinics, did you find whether or not the clinic discouraged or encouraged minors to inform their parents of the – of the fact they were having an abortion?

A. Well, let me say it really wasn't just an abortion clinic.

Q. Uh-huh.

A. It was a combined clinic that provided teen contraception, too. So –

Q. Right.

A. – I don't know whether that's a semantic issue or not. And so it's important to – that there were a number of healthcare issues going on there. In general I think that the persons working at those clinics were not attuned to the need to provide parental involvement.

Q. And in your – your experience and your studies, if, in fact, you have situation where you're not encouraging minors to involve their parents, does that have an effect on whether or not they're going to involve their parents?

A. Yes, if you – I think that young people certainly can be swayed in that – in that area. Encouraging and talking about the positive reasons that a parent might be involved or should be involved I think will have an influence on the teenager.

* * *

Q. Can you explain to the Court the reasons why they give for not informing their parents?

A. The majority would simply say this, my parents will be upset, my parents will be angry. I think they have fears of the consequences of informing their parents, and so they are afraid often for their parents to know. They're embarrassed.

Q. And these consequences, are they concerned about – what are they prominently concerned about in these consequences?

A. Well, I think that most of the young people that I've counseled with, their parents don't either know or haven't accepted the young person's even sexually active, so the fact that they are then pregnant leads them to have more concern about what the parents will do. If I do something my parents disapprove of, they probably disapprove of my sexual activity, they're for sure going to disapprove of my being pregnant, and this is going to put an extra stressor on my parents. So, they are even concerned about their parents I think at times.

Q. And this involves the fact or fear of their parents knowing that they were actually sexually active?

A. I think that's part of it, sure.

* * *

Q. All right. Doctor, regarding a minor, again one of these children who go through abortion, is there a need for long-term emotional support in that abortion decision?

A. Yes. I – if – the decision meaning that if a young person had an abortion, or the decision they made to terminate, I think that they do need adults in their environment, and the parents are the closest to the young person. They do need emotional support. Because as we've talked about, young people may regret the decision they've made later. They may feel depressed, or act out, and that's a term that means adolescents often act out their feelings rather than expressing them, then parents need to be aware of signs to look for.

Q. Do you believe that parental knowledge and parental involvement in the abortion process would assist in providing that long-term emotional support?

A. Yes.

TESTIMONY OF DR. ELKIND

Q. Have you published articles or scholarly works in the area of cognitive development specifically?

A. Yes. It was the major area of my research in which I studied many – I first replicated many of the studies of John Piaget about intellectual development. And

I looked at religious development in young people; I looked at perceptual development, social-emotional development. And then – and I have tried to combine those developmental things with my clinical work, and talked about two concepts, which have been widely used: imaginary audience and personal fable in adolescents, which grew out of my work with delinquent children, which I found that many adolescents – young adolescents believe that they were the center stage, that everybody was watching them, thinking them [sic] about them and so on; and that led to an increased self-consciousness and increased susceptibility to peer pressure. And that's been replicated both here and abroad in many different ways.

And corresponding to that is a personal fabled belief that the young adolescent, that he or she is invulnerable and that – and have a sense of speciality, and that this has sometimes very positive effects but it can lead to risk taking when young people think that it's going to happen to other people and not to me; other people get sick and die, not me; other people are not going to realize their life's ambitions, not me.

And we recently developed a new scale to measure this, and are finding, again, as we found with our scale for them [sic] imaginary audience, that it peaks early in adolescence. The young people – imaginary audience is most powerful in early adolescence, and it appears that young people have this greater sense of vulnerability and speciality in early adolescence as well.

Q. All right. How does this specifically – what you just discussed, the scale and the thought processes of young people in that respect – how does that relate to the opinions you have in this case about Alaska law?

A. Well, it reinforces what we know from a lot of other domains, that it's a very special time of development, and that a lot of things are going on intellectually – Piaget pointed that out – that they are finding new mental abilities.

But it also leads to what I've talked about is a new level of egocentrism, self-centeredness; that is, a temporary stage that happens at each stage of development but that makes young people a little bit more realistic and more susceptible to pressures than – than they will be later one [sic].

Q. And in the context of this case, young women 16 years or younger who find themselves pregnant and considering the option of having an abortion or not having an abortion, how does this relate to them?

A. Well, I think what we know is that making these decisions means that you have to take a number of variable [sic] into account simultaneously, and to think about the social-emotional repercussion, the long-term effects, all of those things have to be taken into account. And we know that young adolescents are not able to do this as well as they well be able to do that later.

Q. Okay. What's the book The Hurried Child?

A. The book The Hurried Child is – was published – first published 20 years ago and reflects my concern with the pressures on contemporary young people to grow up too fast and the stress that produces on them. That book has been – is now in its third edition and was a best seller. It has been translated in ten different languages including Japanese, Chinese, and Korean.

Q. Okay.

A. And the thesis is basically that children are expected to feel and think and behave as older than they are. And when that happens, they – this is stressful. And we see increasing – evidence of increased stress. Like 25 percent of kids today show one or another stress symptoms, and that's an amazing number. Whether it's, in young children, physical symptoms; and school-age children, various learning problems; adolescents, we see it in the form of drug abuse, acting out, sexual acting out, or criminal behavior.

Q. And how, specifically, do those matters discussed in your book relate to the issue in this case, of 16-year-old girls who are – again, who are pregnant, finding themselves facing a choice of whether to abort or not?

A. Well, I wrote a succeeding book called All Grown Up and No Place to Go about adolescents. And the thesis of that book was that young people today are being asked to make decisions about sexual activity, about drug use at an earlier age than ever before; and that because of that, they are asked to make judgments at an age when their judgment is less adequate, when they are most susceptible to the personal fable and most susceptible to the imaginary audience, peer group pressure.

So a lot of the behavior that we see with adolescents, the misbehavior, comes with the fact that they are being pressured to make decisions at an age when they are less able to. Whereas before, adolescents didn't have to make those decisions until 17 or 18. Now they are being asked to make them at 12, 13, whether to have sex, whether to take drugs, and so on. And so we see a lot more stress and a lot more problem behavior because of that.

* * *

Q. Okay. Now I'd like to – you'd mentioned this briefly before, but I'd like you to elaborate a bit. Have you developed a scale to measure adolescent mental development?

A. Well, I – the imaginary audience the personal fable scales are both measures of development, yes.

Q. Can you tell us in more detail exactly what those scales are and how they fit to this case?

A. Yeah. The imaginary audience scale involves items such as you've been invited to a party, and you looked forward to going to that party for a month or so, and as you walk in the door, you notice that there's a grease spot on your skirt or pants, what do you do?

And what we find is that young kids, third or fourth grade, say, well I'll go to the party because I've been looking forward to it. And 16, 17-year-olds say, well, I'll go to the party, you know, I'll – my friends.

The 13, 14, 15-year-olds – we have this on tape as well – they say, well I'll go home; I'll hold any hand out, I'll spill something on it. They are very concerned about it and want to change it and so on, whereas the older and younger – and that's, again, that imaginary audience.

And that has been – that scale's been used across the country by many different investigators. It's been used overseas as well as, and with all similar results in Greece and Turkey and Israel.

Q. Now, what does that scale specifically tell you about the young girls who would be subject to this statute in Alaska? And how does it relate to your opinions in this case?

A. Well, I think that what we – other investigators have shown is that susceptibility to peer pressure, for example, is related to performance on the imaginary – if you're more high on the imaginary audience scale, you're more susceptible to peer pressure. And if that is so, then peer pressure – the pressure to have sex might be – one of the things we know is that the age at which young people have sex is a community-based norm, that – not certainly about parents, but the age in different communities and girls know at what age you're supposed to.

So if there's – if they're susceptible to peer pressure, and if in that community the age is fairly young, then that would certainly contribute to her becoming sexually active.

Q. Are there surveys that you've relied upon which corroborate the notion of teenagers having unrealistic expectations?

A. That –

Q. Corroborate the notion of teenagers having unrealistic expectations as you've –

A. I'm – either my hearing is going or I'm not following you.

Q. I'm wondering if there are surveys that you've relied upon in forming your opinions which corroborate the notion of teenagers having unrealistic expectations in their decision-making?

A. There are a number of studies. I think Susan Harter's work, for example, she's a long-time student fo [sic] self-development, and she's developed many scales, and her – is the sort of noted authority in the field. And

she believes that young adolescent girls and boys are – don't really have a good sense of self yet and not fully developed.

So that I think that, again, is further evidence for this kind of fact that it's a period when the – when Eric Erickson talked about the sense of personal identity is just being formed and that young people do not yet have a full sense of themselves and they are – which he found was that – sort of – she found stages in development, but that in early adolescence is when kids have contradictory ideas about themselves. They haven't yet integrated them. And so they have some ideas of, you know – that really don't fit together very well.

Q. Can you tell us how these unrealistic expectations of teenage girls 16 years or younger would come into play in the context of a young girl who finds herself pregnant considering abortion or not abortion?

A. Yeah. I think one of the things we see is that often young girls may have unrealistic expectations about the baby. And it's, you know, that the baby's just going to be loving and caring and it's going to be wonderful. They don't have – are not really aware of the crying and the changing diapers and staying up all night and all the other things. They have a very sort of idealistic unrealistic idea of what having a baby is going to be like.

APPENDIX C

TRIAL TRANSCRIPT SELECTIONS FROM NORTH FLORIDA WOMEN'S HEALTH AND COUNSELING *SERVICES, INC. V. STATE*, IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA, 1999.

TESTIMONY OF DR. ADLER

Q And it's an article in the Journal of Social Issues entitled, "Unwanted Pregnancy and Abortion Definitional and Research Issues." Do you see that?

A. Yes.

Q And is that your article?

A. Yes, it is.

Q Now, I want you to look to page 29 of that article.

A. Okay.

Q And ask you to – whether you still agree with this statement, quote, "Although differences may have not been empirically demonstrated, adolescents may be somewhat more likely than adults to experience negative responses following abortion for several reasons. One reason is that a relatively greater proportion of adolescents may terminate pregnancies that are, at least to some degree, wanted or intended. Adolescents may be more vulnerable than adults to pressure to abort, particularly for parents."

Do you still agree with that statement?

A. No, I don't. I do, in that I was using the term "may" and it was speculation. I think that's one of the

reasons we did the study that we did do, looking at whether adolescents were, in fact, showing more negative responses. Given the data that's come out since then, I don't think this speculation is borne out, so again, this was – given that I said the word "may," it is certainly possible, but the data now are suggesting that it's not the case.

* * *

Q Are you familiar with the Soderberg study in 1998 of Swedish women, of 1,285 women who had undergone abortion?

A. Silverberg?

Q Soderberg, S-o-d-e-r-b-e-r-g.

A. Not off the top of my head, no.

Q Would you look at number 11 of what we've attached?

A. Sure. Okay, yeah, I have it.

Q And you're not familiar with this study of 1,285 women specifically on the issue of their having undergone an abortion and the emotional distress that it caused?

A. Yeah, actually I have seen this. I haven't studied it particularly because it's a non-U.S. sample, but I have seen it.

Q I want you to look at the abstract of that study.

A. Sure.

Q And looking at page 173.

A. That's the abstract, or – I'm sorry, yeah, the abstract on page 173, right.

Q And I would ask whether that you would agree with the conclusion that, "Thus, 50 to 60 percent of women undergoing induced abortions experienced some measure of emotional distress, classified as severe in 30 percent of cases, and furthermore that emotional distress following induced" – then the citation to the Soderberg study, I'm sorry.

A. You know, what I'd need to review is what their measure of emotional distress was, whether they used a standardized measure, how it was characterized. I'm just trying to jump ahead to see if I could see what they used.

Again, in a non-U.S. sample, it's a little hard to know what their measures were.

I'm just looking actually at their methods selection, and it looks like they'd had a semi-structured interview and they were determining it on the basis of an interview. It doesn't look – they don't report any – they didn't use something like the Beck's Depression Inventory. You know, as I was talking about yesterday, it really – on [sic] of our criteria is you have to have some kind of standardizing measure to be able to benchmark it, and it looks, in looking through this, I don't see that they used that, so it makes their conclusions a little hard to evaluate.